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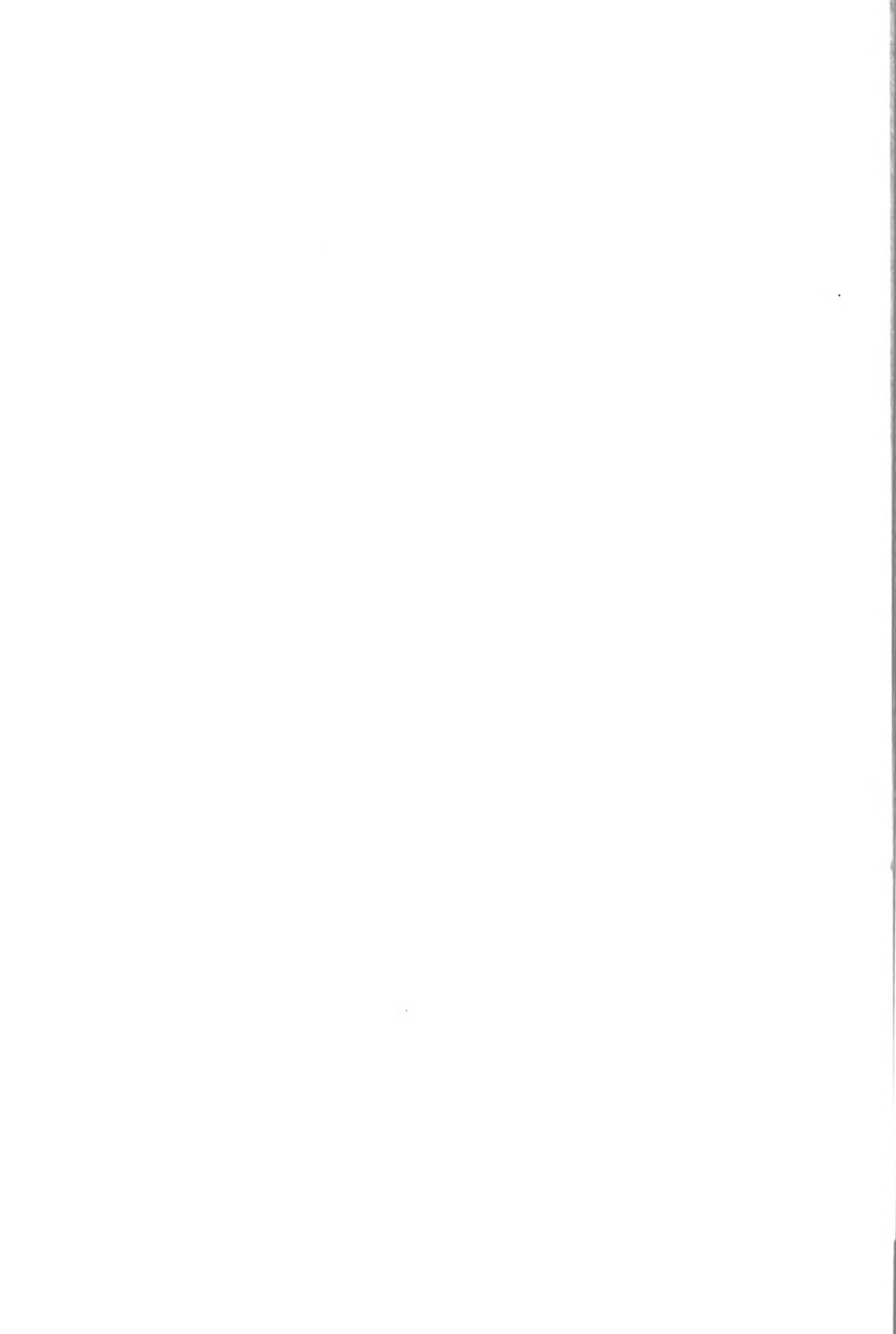
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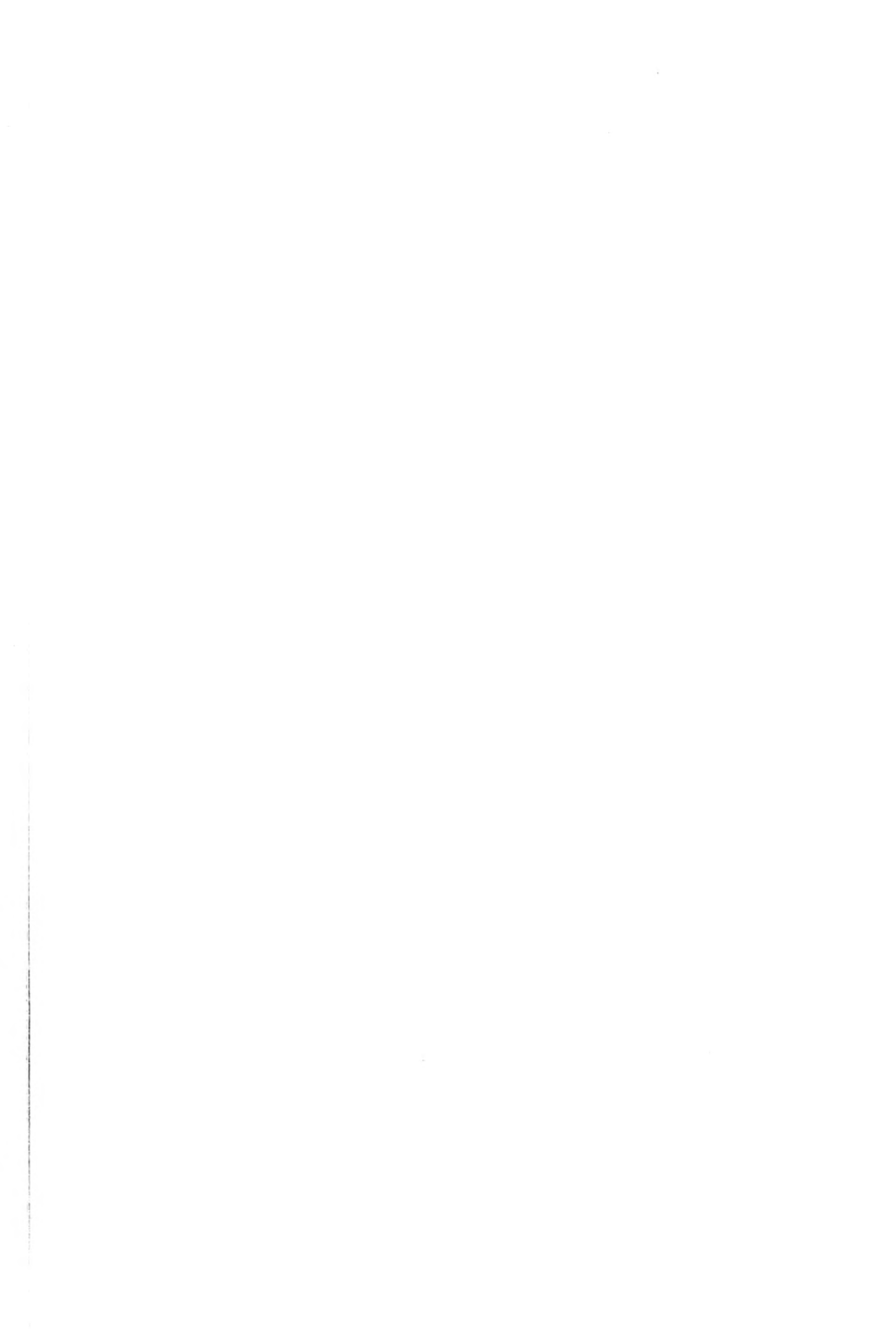


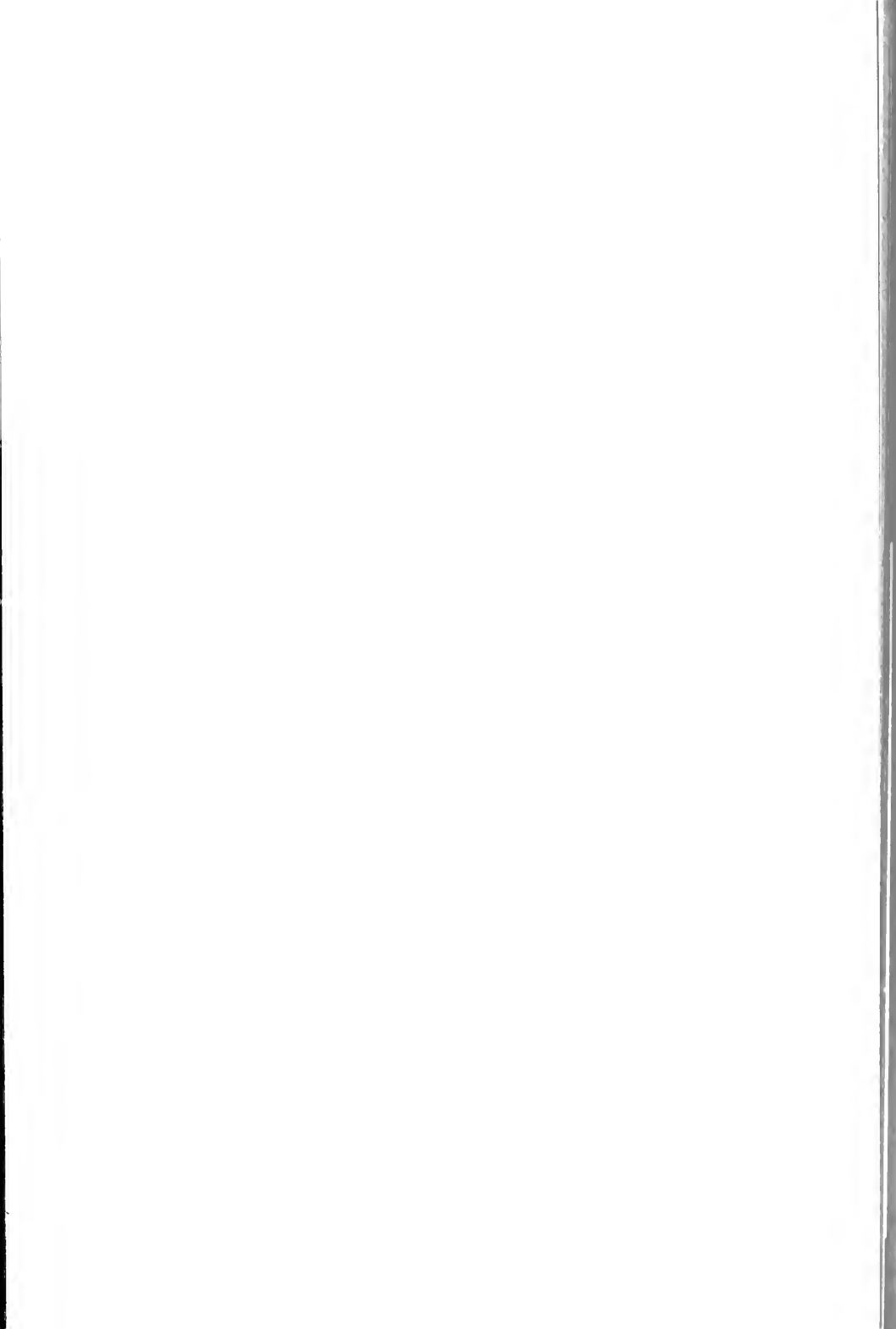
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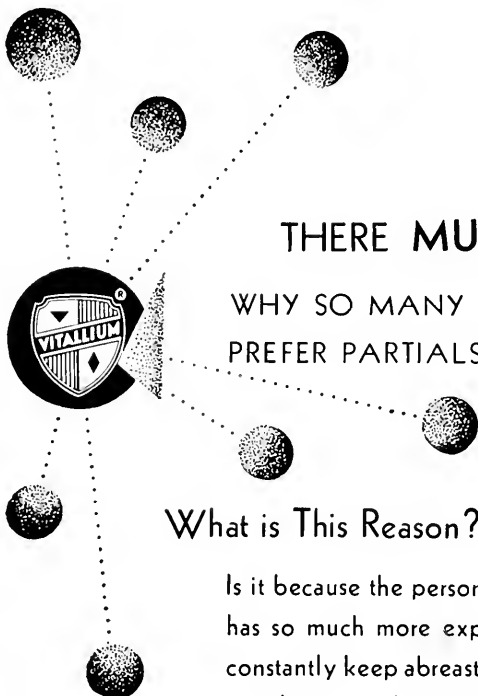


**JANUARY 1972**  
**VOLUME 55 NUMBER 1**

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**THE**  
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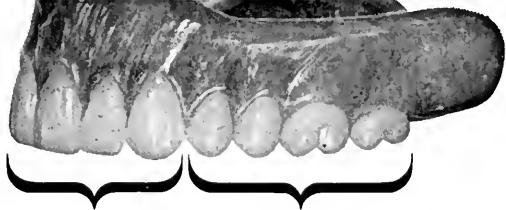
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# THE JOURNAL of The North Carolina Dental Society

(A Constituent of the American Dental Association)

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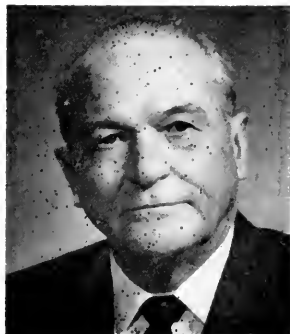
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# The President's Page



THE GREATEST RESPONSIBILITY of the Officers and the Central Office is to adequately serve the total membership of the North Carolina Dental Society. The membership must be kept informed on all measures and problems that effect the profession now and in the future. Unfortunately, the North Carolina Dental Society *does not* have the necessary funds to attempt to do many things we need to be doing.

It will be necessary to request certain members to do research in various areas and to present a condensed version of these topics for publication to the membership in an effort to inform the membership. This will be a time consuming imposition on some but it appears to be our only means of better condensed information for our membership.

Many of the demanding problems facing dentistry involve the varied approach and philosophies of Dental Education, the State Board, and the Dental Society. As varied as these philosophies appear to be, it becomes more vitally necessary for these three interests to have the support and understanding of each other if their efforts are to become totally effective. The healthy situation of philosophical differences will remain, but the successful resolving of problems must, by necessity, become a mutual effort as these problems encompass all these interests. Changes of approach and modification of philosophies must be made as the *status quo* cannot be maintained. A concentrated effort must be made to improve communication and understanding between and within these agencies. We need an Inter-agency Committee of these interests, together with the Department of Oral Hygiene, to resolve some of the problems that effect each agency. This Interagency Committee should have the financial support of the Society, as they would develop direction and guidelines to the best interest of all agencies for the consideration of the House of Delegates. The general membership and the members of the House of Delegates are not as close or as informed on some issue as these agencies which have to live daily with many problems and demands which effect the total profession.

Several industries, with many employees in North Carolina, have accepted in contract agreement, a dental health care program for their employees and their families. If the North Carolina Delta Plans, Inc. had the required 900 participating member dentists it would be serving these families rather than the delta dental plans of California and Ohio. The

activation of the North Carolina Delta Dental Plans, Inc. is long past due, and a concerted effort must be made to secure enough participating members for this health service to the public of North Carolina. Maybe the participating agreement needs immediate study and possible revision for a greater acceptance by our membership. The Insurance Commissioner has indicated that 900 participating dentists are required before the cooperation will be licensed. New insurance programs are being planned in North Carolina to provide dental coverage to elementary school children and this planned development practically demands the immediate activation of the North Carolina Delta Dental Plans, Inc. before it will be too late.

The Insurance Committee of the North Carolina Dental Society is quite concerned about our own personal insurance programs, and at the committee's recommendation, the Executive Committees has contracted an insurance consultant to completely evaluate our programs. It is believed the results of this contract will upgrade our programs and will reduce our cost. The Society will not receive any refund on this investment but the participating members will be benefited. The Insurance Committee is commended for its study and recommendations.

The research project (DAU) to study the utilization of dental auxiliaries is being conducted at the North Carolina School of Dentistry. This research, conducted under the strict discipline and quality controls of the School of Dentistry, will in time produce documented and valid conclusions in the needed expansion of auxiliaries in private practice. We have labored with this problem for years, and the DAU research program will provide our membership and the State Board with an opportunity to work together with the School of Dentistry in a program that could prove to be for continued progress for the profession and for increased services to the public of North Carolina. This research will provide valid and qualified direction in the needed expanded utilization of dental auxiliaries.

The Dental Care Programs Committee has held many meetings with Blue Cross and Blue Shield, Inc. this year. This committee has diligently sought many permissible services under the Medicaid program. Permissive services are now codified and a revised manual on dental services covered under the Medicaid Program has been developed for the approval of the Department of Social Services. Upon approval by the department it will be distributed to all participating members.

The Department of Social Services on December 7 notified North Carolina Blue Cross and Blue Shield that the state's contract with Blue Cross and Blue Shield for the administration of the Medicaid program would not be renewed after it expired on December 31. The department announced that it plans to administer the program itself and save a significant amount of money. However, Blue Cross and Blue Shield has questioned the department's claim that it will save money by the change. In the future then, the Dental Care Programs Committee will be negotiating directly with the Department of Social Services on Medicaid matters.

The Central Office must vacate our present facilities by August 1972. The Central Office Site Committee has reported to the Executive Committee on several occasions. We were just too late in making a fine in-

vestment for a Central Office on one recommendation. The Executive Committee has received 13 other proposals for relocating the Central Office and 3 of these sites were visited by the Executive Committee. A cost study of purchasing property and constructing a central office building is now being made by a special committee to report to the next Executive Committee meeting.

Our District Meetings all had excellent programs and fine attendance. We welcomed 85 fine new members into organized dentistry. A concerted effort should be made to enlist non-members. The demands, the interventions to the profession, and the ever-increasing problems of today involve all dentists, and non-members need to participate in the efforts of the profession to resolve these issues, and non-members need to express their participation and support for the best interest of the present and emerging profession of dentistry.

We should make some effort to introduce dental students to the activities of organized dentistry. A means could be devised to have two elected representatives from each class of the School of Dentistry to be seated in the House of Delegates with the privilege of the floor but without vote. This would introduce them to the workings of the House and organized dentistry. These students are our future members and they want to learn about the activities and programs of their chosen profession.

The 19th District Officers Conference was well attended, regardless of the snow, and many recommendations were made for the consideration of the House of Delegates.

The Workshop on Specialty Licensure resulted in the recommendation to amend the General Statutes to provide for specialty licensure and a tentative draft of the specialty licensure amendment was approved and directed to the Dental Practice Act Committee and the House of Delegates for consideration.

There are many areas of interest not mentioned in this report, but dentistry in North Carolina is at work. The Officers, the Central Office, the Executive Committee, and the members of the House of Delegates need your expressions, your guidance, and your opinions as many areas of importance are not resolved. The North Carolina Dental Society, its accomplishments, and its present and future position, will be no greater than our contributions to its advancements and progress. The dedication of our members will be evident in the years ahead.

WADE H. BREELAND

# **Editorials**

## **CONCERN FOR THE NCDS**

During the past fifteen years a significant number of people in North Carolina have become eligible for prepaid dental treatment. These have risen primarily through third parties such as union-management groups, state agencies and federal programs. It seems apparent that the impending legislation to provide a national health service in the Congress will increase the numbers of eligible people at a rate that may be either rapid or explosive. It should be obvious to us all that whether we like it or not, some type of service will be available to the masses and very soon. It should also be obvious that North Carolina should have some guidelines to guide a rational program development. We have seen a very unsatisfactory administration from the dentist point of view in the past two years with Medicaid, wherein the State Department of Social Services and North Carolina Blue Cross and Blue Shield doled out percentage fees for services. At first there was general satisfaction among the dentists. Then last year the gravy was cut from the medicaid program reducing it to extractions and restorations. This is unacceptable. Yet one avenue of relief from this situation lies fallow for lack of interest from the people who will benefit from it most.

Other states have developed their Delta Dental Plans and are now actively competing for third party prepaid dental contracts and controlling them. In North Carolina we are sitting on our cans and bitching about what "they" are doing to us. If we have the decency to support our own

program, get it activated and start competing for these services, we could salvage some of the control of dental services and the compensation therefrom. I personally have no sympathy for those of you in the society who fence ride and are too penurious to contribute \$50.00 to a program that can bring back millions to your offices in the next few years.

When North Carolina Delta Dental started its drive last year for subscribers we needed a minimum of 900 participants, one half of our society, to support it. To date we are just about half way there and the drive is foundering. If this thing fails, the state society's individual dentists can blame themselves and no one else since they didn't see fit to contribute. In the coming years when you are enundated with patients on a "free Dentistry" road for which your compensation will be meager and you start looking around for someone's tail to kick for getting you in the mess, just look in the mirror.

If North Carolina dentistry is going to have any voice at all in dentistry in the coming years, we had better get together now and support an organization of our own which can offer alternative programs. If we don't, we'd better get ready for some federal supervisor to tell us what our quota of services will be in the next pay period and we can kiss free enterprise good-by.

Dentistry in North Carolina has always been a cut above in quality. We've been proud of the services that we deliver to the people in this state. It's just too bad that so many

of us are so apathetic toward working for dentistry that we won't join in to preserve what we have. It is urgent that all North Carolina Dentists who have not contributed to the North Carolina Delta Dental plan to do so at the earliest possible moment. Time is of the essence, and if we can get our program off and rolling this year we can be in a good bargaining position to secure the various contracts which will be available as a result of the direction national health services is taking. Failing this it would appear that the only other agent in North Carolina to qualify for administration of the program is the current one. If you are happy with that, you deserve it and what it will do for and to you later.

BRB

### **1971-72 ADA RELIEF FUND CAMPAIGN**

In the past two years, the American Dental Association Relief Fund contributions have fallen short of the \$125,000 national campaign goal. The ADA Council on Relief raised the campaign goal to its present level in 1960. That goal was surpassed in seven campaign years during the past decade, but not during the last two years.

Overshooting the goal when it comes to helping our colleagues has been a tradition within the profession — at least until recent years. The Relief Fund was founded on the excess of funds donated following the San Francisco earthquake and fire in 1906. After the homes

and offices were replaced, the \$3,-969.75 left over was used to launch the fund as a perpetual source of help to less fortunate colleagues.

Now that contributions to the Relief Fund have fallen back in the last few years, the state dental societies are the ones feeling the squeeze. Three-fourths of all the money collected in the national campaign is turned back to the states for their relief efforts. If the state meets its individual quota, it is eligible for 100 per cent return if its regular refund has been exhausted in relief grants.

The recipients of these grants are all ages, some very young practitioners who have not yet built an insurance or emergency program adequate to take care of themselves and their families. They include the dentist in his 20's who died from a massive brain tumor, leaving his dependents, no insurance and a mortgaged practice. Another dentist in his 40's was involved in an automobile accident and sustained a severe back injury. His wife couldn't work because of young children, and he was heavily in debt. Another dentist in his 50's was unable to practice for over a year because of a foot amputation and complications. He had four children.

The need is there. The Relief Fund officers haven't asked us to overshoot our goal as we did in the old days. They have only asked us to just reach it. It's an old dental profession tradition that's worth renewing.

# Book Reviews

**Dental Assisting Correspondence Textbooks.** Second Edition. University of North Carolina Press.

The UNC Press has recently released the second edition of the 7 Dental Assisting Correspondence Textbooks developed at the UNC School of Dentistry. These textbooks have been widely recognized for their complete coverage of dental auxiliary utilization content. The books have been updated and expanded.

The radiology section is completely revised to provide instruction to assistants in exposing radiographs. This includes material to cover the 40 clock hours of instruction required by the N. C. Board of Dental Examiners for radiology.

The books are valuable resource materials for private office auxiliary training on the job. They have been accepted by many schools throughout the country to serve as the primary source of instruction in the course content of the dental assistant curriculum. The books are available in complete sets or by individual purchase.

For information write: Bureau of Correspondence Instruction, UNC Extension Division, Chapel Hill, N. C. 27514.

BENJAMIN R. BAKER, D.D.S.

**The Modern Family Guide To Dental Health.** By A. Norman Cranin, D.D.S. \$8.95. Stein and Day Publishers.

This is the first complete home dental reference book. According to *The Kirkus Service*, it provides "All you need to know, very accessibly presented."

Dr. Cranin is the Director of Dental Services of the Brooksdale Hospital Center in Brooklyn.

According to *Kirkus*, "This is a maximally clear job of explaining everything: the kinds of pain and decay; the choice of dentist and his examination; the bite; drilling and filling (silver vs. gold, porcelain vs. plastic); pulp therapy and periodontal disease; crowns and caps and replacements extending from partials to complete dentures which he expects to become a thing of the past with proper care."

**Periodontal Catalogue.** The American Academy of Periodontology. \$3.00.

This catalogue was compiled to provide the dentist with a comprehensive source listing of professional and patient-oriented periodontal instructional aids.

The new publication, believed to be a first in the field, provides information on both printed and audiovisual materials which have been developed by individual dentists, schools, organizations and commercial companies.

The Catalogue indicates where each item may be obtained, either by purchase or free.

Materials listed in the Catalogue include films, slides, booklets, posters for patient education and complete audiovisual instructional materials on anatomy, pathology and treatment procedures for the dentist.

A special section on oral hygiene aids has been included in the Catalogue, and within this section are listings of manual and electric toothbrushes, dental floss, irrigating de-

vices, disclosing tablets and solutions and packaged oral hygiene kits.

The Catalogue has been compiled by the Public and Professional Relations Committee of the AAP. Single copies of the *Periodontal Health Catalogue* are available for purchase at \$3.00 each, prepaid from the American Academy of Periodontology, 211 East Chicago Avenue, Room 924, Chicago, Illinois 60611.

**Occlusion.** Sigurd P. Ramfjord, L.D.S., M.S., Ph.D., and Major M. Ash, Jr., B.S., D.D.S., M.S., University of Michigan School of Dentistry. Second edition 1971. W. B. Saunders Co.

This is an excellent text for the student, teacher, or practitioner. The text is now in its second edition and is well documented and includes much new data and many new photographs, diagrams, and radiographs. The text is written in good sequence and includes three sections. The first, "Anatomy and Physiology of the Masticatory System," encompasses boney anatomy, muscular anatomy, the nervous system, and the physiology of occlusion. "Functional Disturbances of the Masticatory System," the second section, deals with bruxism, traumatic occlusion, muscular and periodontal responses to traumatic occlusion, and traumatic arthritis and osteoarthritis of the T.M.J. The final section deals with the "Diagnosis and Treatment of Functional Disturbances of the Masticatory System." This section includes the methods of diagnosis, the use of articulators in occlusal therapy, minor orthodontic therapy, occlusal adjustments of natural teeth, the im-

portance of occlusion in operative and restorative dentistry and occlusal splints. The text is concluded with several case histories that demonstrate the proper approach to gathering sufficient data to initiate occlusal therapy.

The text is well written and uses many subtitles so that certain items can be located rapidly. The many diagrams, photographs, and radiographs offer a great deal to the reader.

RANDOLPH L. KIXMILLER, D.D.S.

**Modern Practice in Crown and Bridge Prosthodontics.** By John F. Johnston, D.D.S., Ralph W. Phillips, D.Sc., and Roland Dykema, D.D.S., Indiana University School of Dentistry. Third edition, 1971. W. B. Saunders Co.

The text is a very thorough guide in the art and science of crown and bridge prosthodontics. It begins by devoting the first two chapters to a discussion of indications, contraindications, differential diagnosis, and treatment plans. These are probably the most important chapters in the book because unless the clinician understands the basic concepts of diagnosis and treatment planning the most beautiful bridge or ideal preparation is not worth a minute of the operator's time or a penny in fees. The bulk of the text deals with the tooth preparation and construction of the many different retainers and types of coverage used in crown and bridge prosthodontics. Both laboratory and clinical procedures are included in such chapters as, "Wax patterns, Spruing, Investing, and Casting; the Pontic; Pontic Form; Soldering; Glazing and Staining Facings," and many others.

Two completely new chapters have been added to this edition, one on aluminous porcelain jacket crowns and the other on forming functional occlusal relationships in wax. Specific problems such as orthodontic repositioning, splinting, and fabrication of abutements for removable partial prosthesis are also discussed. The text is rounded out with a discussion of bridge failures and several case histories.

Technically the text is well written and is well documented. Every aspect of crown and bridge prosthodontics is covered including the dif-

ferent dental materials, their uses, and their handling characteristics. There is even discussion of the different types of dental equipment and their usage in crown and bridge fabrication.

The photographs and illustrations are all well done and laid out in a meaningful manner.

This text is ideal for the student, dentist, and technician who desires to have the laboratory and clinical knowledge necessary for the practice of sound crown and bridge prosthodontics.

RANDOLPH L. KIXMILLER, D.D.S.

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# The Theory and Rationale Behind Ultrasonic Scaling

By Frank R. Pfau, D.D.S.

*The author is in private practice of Periodontis in Winston-Salem, N. C.*

IT is possible to debride tooth surfaces and encourage healing of periodontal lesions by producing clean, smooth, and even surfaces through the use of ultrasonic vibrations applied to appropriate instruments. Thus, ultrasonic vibrations can scale, plane, rub, and abrade teeth to free them of calculus, plaque, food debris, stain, and affected cementum. Ultrasonic scaling is a particularly useful technique in the treatment of the following:

- (a) Marginal gingivitis — calculus and plaque removal
- (b) Pre- and post-surgical scaling
- (c) Acute necrotizing ulcerative gingivitis — bacterial and necrotic tissue removal
- (c) Dilantin hyperplasia — circumferential calculus removal

All instruments have some effect on tooth surfaces, but the general opinion is that curettes leave the tooth surface smoother than any other type of instrument. It has been pointed out by Meinig that dentists do not take sufficient time to hand-scale the teeth properly.<sup>1</sup> The routine and thorough removal of calculus is to keep the irritation at a level that the tissues can tolerate. There is a great value to be realized by hand scaling when the necessary sense of touch and ability to perform a thorough and complete scal-

ing have been developed by the practitioner.

An evaluation of ultrasonic versus hand instrumentation deserves a separate cover. It is highly desirable to perfect "hand" technique, as this will best serve to aid in manipulation of the ultrasonic device. The vibrations of ultrasound tend to remove the tactile sensation of the operator, thus, making the operator dependent upon positioning the instrument tip by means of visualization (direct or indirect) and a proprioceptive sense (spatial orientation). Conversely, it is true that utilization of the ultrasonic instrument will *not* enhance performance in hand scaling. Therefore, it becomes germane to first develop an understanding of the instrument to complement the scaling armamentarium and therapeutic approach toward resolution of gingival inflammation.

The various unit models marketed by manufacturers represent a sudden transition from manual instrumentation. It is hoped that one can justify the operation of ultrasonic instruments after analyzing the microscopic observations to be elucidated below.

## Electronic Basis:

When a coil of copper wire is wound around a plastic cylinder and alternating current flows through the coil from an oscillating electric current supplied by a generator, a magnetic field is created.

In the application of ultrasonic energy to periodontal instrumentation a magnetostrictive transducer producing about 25,000 vibrations per second is employed. The magneto-strictive transducer or insert, lying within the cylinder and bathed in flowing water, contracts in step with the current vibrations. When the current goes from maximum to zero at the end of an alternation, the insert (transducer) returns to its original size.<sup>2</sup> These changes in shape provoke an amplitude of *vibration* which expresses itself as reciprocal motion, the fundamental element in ultrasonic instrumentation. The *amplitude* represents the traveling distance of the "working end" of the periodontal tool which approximates .0015 cm.

Ultrasonic waves traveling any distance and reaching an interface or junctional surface are dissipated in the form of heat. This is reduced by running water which is expelled at the working end through a metal tub. In a liquid medium these waves agitate its molecules, thereby drawing out of solution gases which have been previously dissolved or entrapped. The released bubbles burst open with tremendous local pressure; this bubbling action or *cavitation* enhances the cleansing action in the gingival crevice.

Finally, the motion of a tip depends upon its design: pure reciprocal motion produces knocking and hammering; elliptical motion produces scraping and cutting. Sonic energy, then, is made up of waves that mechanically hammer, knock, scrape or cut, and that produce cavitation (bubbling action) and generate heat through absorption. The heat generated in the magneto-strictive transducer is relatively high;

this loss of energy in the form of heat is termed "hysteresis loss."

### **Mechanical Action:**

Ultrasonic instruments are reciprocal action devices which move in a push and pull. Since the vibrations are sufficient to dislodge deposits, it is preferable that for gross scaling they remain dull to avoid inadvertent planing of root surfaces. Root planing is accomplished by using the convex or rounded surfaces of vibrating ultrasonic tools lightly and quickly over the areas to be polished.

With slow, even regular strokes passing over the root surfaces of extracted teeth, root surfaces are rubbed gently. Fragmentation and dislodgement of calculus takes place, leaving the surface visibly debrided of surface accretions. Comparison of the root or cemental surfaces of these teeth reveals a series of fine scratches and lines following hand scaling and an apparent absence of markings following ultrasonic scaling.<sup>3</sup>

### **Microscopic Wound:**

A study of the wound produced by ultrasonic coagulation in soft tissue curettage has been conducted by Ewen in animals and humans to observe the immediate and subsequent effects at the clinical and microscopic levels.<sup>4</sup>

With ultrasonic curettage crevicular epithelium was removed and white strips of tissue emerged. Bleeding was minimal and/or less noticeable due to the presence of water irrigation, and surface injury to the free marginal gingivas negligible.

The crevicular epithelium was either coagulated, shredded, or miss-

ing. The underlying corium showed typical fusion of collagenous connective tissue bundles. The coagulated surface stained darkly, similar to necrotic or burned (electrosurgery) tissue. Collagen bundles were forced apart, condensed in appearance, or fused into diffuse masses. The nuclei of the fibroblastic cells were pyknotic or irregularly condensed, and hence hyperchromatic.

Within three to five weeks complete healing took place and no difference could be detected microscopically between gingival tissue treated with hand curettage and that treated with ultrasonic curettage.

While the removal of epithelium cannot be explained entirely on the basis of coagulation by heat, separation may be due to the accumulation of energy at the interface of the basement membrane and underlying corium. Another possibility is the shearing effect from a change in the direction of the sound waves at the interface (the plane or depth at which the sound waves disperse).

### **Preparatory Steps:**

#### **The Chair-side technique involves:**

1. Draping the patient and placement of an absorbent towel
2. Positioning the mandibular arch horizontally so as to assure evacuation of water flow
3. Placing the saliva ejector — this *is* adequate to remove any amount of fluid collection
4. Applying 2 per cent topical lidocaine to achieve superficial soft tissue anesthesia
5. Setting the amount of power on medium and depressing the foot-control in order to fill the handpiece with water; inserting the specific scaler inserts and tuning the instru-

ment by arriving at the greatest level of "hissing."

6. "Bursting" of the strong fluid jet at the very tip of the insert when properly tuned

7. "Brushing" the tip over the accretions until they dislodge from the tooth surface

8. Directing the tip of the instrument perpendicular to the long axis of the tooth is not advised, as this will groove or notch cementum and dentin

9. Depressing the foot-control for long periods of time, since sporadic on — and — off motion is wasted time and motion, noisy and irritable, as well as damaging to the equipment

10. Depending upon the severity of the calculus present, the time interval should occupy between 20 minutes and 45 minutes for a full complement of teeth

11. Sterilizing the tip by first wiping with 70 per cent alcohol and placing in cold sterilization; then, prior to its next use, actuating the tip in the cold sterilizer for 10 seconds to assure microbial death via ultrasound

### **Conclusion:**

In conclusion, one should value the possible limitations of this modality, especially in regard to the penetration potential of ultrasonic waves.

Since the ultrasonic instruments are contraindicated for clinical use on young, growing tissues . . . treatment of children should be avoided.

Osseous tissue should be kept at a respectable distance in areas under treatment; one should avoid underlying bone in order to prevent local osteitis and sequestration.

With the aforementioned material

to serve as a guide, this modality may be added to the office armamentarium under the realization that it be used with discretion and respect.

Only calculus recognition, skillful removal on a regular basis, and allocation of sufficient working time will improve the patient's health and retain the natural dentition for a longer time.

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# Endodontic Considerations in Occlusal Adjustment

By William Myers, D.D.S., and  
David Whitaker, D.M.D.

*The authors are graduate students  
in Endodontics at UNC.*

**C**LINICAL Endodontic therapy may appear far removed from the field of occlusal adjustment. An in-depth view of these two facets of dentistry, however, reveals some interrelated aspects that have significant clinical value.

In the differential diagnosis of pain, occlusion plays a prominent role. Pain syndromes of temporomandibular joint disturbances and muscles of mastication can be easily misdiagnosed as pulpal pain.<sup>1</sup> In these cases occlusal evaluation is indicated prior to pulpal extirpation. Percussion, a common test in endodontics indicating pulpal death and subsequent periapical involvement, is only a valid diagnostic test once excessive trauma has been ruled out. These cases may require study models and a complete occlusal analysis many times.

## **Cracked Tooth Syndrome**

One of the most difficult diag-

noses to make is that of an incomplete coronal fracture or the cracked tooth syndrome.<sup>2, 3, 4, 5, 6</sup> Cameron feels the cracking of intact teeth without caries or restorations can only be explained as a result of prolonged hammering. Sixty percent of his cases have histories of discomfort from one month to ten years. Most of the occlusal surfaces had wear facets and showed evidence of bruxing. Others had evidence of steep cusps and deep fossae, where wedging could explain the cracking. An uncemented inlay under occlusal stress acts to wedge the cusps apart. Thoma<sup>7</sup> describes fissured fractures which would allow bacteria to invade the pulp where occlusal stress opens the fractured segments. Stanley<sup>6</sup> and Sturdevant<sup>4</sup> note that proper restoration of teeth allows masticatory forces to be spread evenly over the occlusal surface, not as a wedging force between cusps.

## **Periodontal—Endodontic Consideration**

Rabinowitch<sup>8</sup> feels that internal resorption may be caused by trau-

matic occlusion. He cites a case of internal resorption where there was no history or evidence other than continued bruxism as the etiology.

Pulpal degeneration in periodontally involved teeth was noted as early as 1927 by Cahn.<sup>9</sup> This observation has been questioned by Massler,<sup>10</sup> Rubach and Mitchell,<sup>11</sup> and Seltzer, et. al.<sup>12</sup> Histologic evaluation of roots of periodontally involved teeth revealed lateral canals are abundant in posterior teeth. Accessory canals are usually found in the apical third of roots and furcation areas show a multitude of accessory canals. A periodontal lesion which encompasses any of these vascular channels will introduce bacteria directly into the pulp. Deep curettage of these pockets may disrupt vascular and neural connections to the pulpal tissues resulting in retrograde pulpitis.

Glickman<sup>13</sup> has confirmed that trauma within normal limits will not cause destruction of the periodontium. The added factor of inflammation will result in the usual sequence of periodontal destruction which does include inflammation of the vascular network and loss of the alveolar supporting tissues. This may result in exposure of accessory canals, anachoresis of bacteria into the inflamed vascular beds, and pulpal involvement. Glickman<sup>14</sup> also found that furcation areas of the periodontium are most sensitive to injury from excessive occlusal trauma. Realizing that bacteria may travel both ways in lateral and accessory canals a necrotic pulp can cause a periodontal membrane breakdown leading to a periodontal lesion. Either endodontic therapy or endodontic and periodontic therapy must be utilized to regain a healthy periodontium.<sup>15</sup>

Another area of endodontic-periodontic considerations is the modification of occlusal force where root amputation or hemisection is indicated or where periodontal support is otherwise diminished.<sup>16</sup> In these instances a narrowing of the occlusal table buccal-lingually will reduce occlusal stress to the point where it is proportional to the decreased periodontal attachment.

### **Periapical Healing-Occlusal Trauma**

Following endodontic therapy, a periapical area will not heal when subjected to excessive trauma. Ingle<sup>17</sup> notes that osseous repair was precluded by bruxing. Stahl,<sup>18</sup> et. al. conclude that periapical inflammation in the presence of vertical occlusal trauma caused marked resorption of the interradicular septum with replacement by fibrous connective tissue. Also, he noted that periapical inflammation following pulpal involvement, in teeth without occlusal trauma, caused resorption of the interradicular bone, which was limited to the apical level and followed by highly active osteogenic repair activity. Natkin<sup>19</sup> also reports that periapical healing can be deterred in the presence of bruxing. Considering the preceding studies and findings Shank'e,<sup>20</sup> in 1960, began to remove cusps and occlusal contacts from all molars and maxillary premolars. This is done before endodontic therapy is instituted facilitating better access to canals, more distinct reference points for length determination, less discomfort between appointments, less chance for fracture prior to proper restoration, and more rapid healing of the periapical area.

## Pulp Stones

Dystrophic calcifications, sometimes visible as pulp stones, have been attributed to traumatic occlusion.<sup>21, 22, 23, 24</sup> The significance of these calcifications in endodontic therapy is apparent. The question of pulp stones causing pain has been considered. Seltzer and Bender<sup>25</sup> feel that it is still questionable, although they state that as the calcification gets larger it can create pressure against nerves in the vicinity. Nevertheless, almost all pulps have some calcifications within them. Shroff<sup>26</sup> points out that with an increase in age the volume of the pulp cavity becomes increasingly smaller as a result of continued deposition of dentin on the walls. The decreased volume results in a decrease in the number of circulating cells while the apparent increase in collagen fibers is more relative than absolute. Stanley<sup>27</sup> notes that anterior teeth have more collagen than do posterior teeth and that collagen in the root canal was more concentrated than in the pulp chamber. The amount of bundle collagen increased in the root pulp tissue while the amount of diffuse collagen decreased from the ages of ten to forty-nine. Irregular dentin was indicative of an increased collagen content in pulpal tissues. He concludes that increased collagen is a direct result of previous irritation or stimulation to a vital pulp rather than a result of the aging process. James,<sup>22</sup> et. al. also noted that the number of circulating cells decreases as the fiber content increases. With fewer undifferentiated cells available for emergencies, the defense and repair processes are proportionately decreased. Therefore, with occlusal wear the defensive ability of the pulp

in response to a direct injury is impaired.

## Occlusion Vs. Pulp

At the conclusion of the second International Conference on Endodontics in 1958,<sup>28</sup> there was listed in the final summation the following statement: "There is a possibility that in rare cases bruxism may cause the death of the pulp." The effect of excessive occlusal forces on the pulp have been debated for many years, but little definite scientific data has been presented from which to draw conclusions. Bhaskar and Orban<sup>29</sup> in 1955 produced experimental occlusal trauma in Rhesus monkeys. Their conclusions were that occlusal trauma does not produce gingivitis, periodontitis, pockets, pulp stones, recession, festoons, clefts, erosion, or caries. Landay, et. al.<sup>30</sup> in 1970 used thirty-four Wister rats in an experiment to show effects of excessive occlusal force on the pulp tissues. They concluded that a high amalgam restoration in rat molars is not a good method of producing severe occlusal trauma for long periods. They found that their experimental model produced light occlusal force in the periodontal ligament and these forces were most severe in 14, 16, and 20 day specimens. They found that the light forces over short periods did not cause pulpal changes in the teeth of their rats when examined at the light microscope level.

Cutwright,<sup>31</sup> graphically demonstrated with perfused block sections the circulation of the pulp, periodontal ligament, gingival tissues, and alveolar bone. He concluded that these areas were continuous and interconnected. Bhaskar,<sup>29</sup> Gracey,<sup>21</sup> Lieban,<sup>32</sup> Stahl<sup>18</sup> et. al., McCall,<sup>23</sup> Leonard,<sup>33</sup> Natkin,<sup>21</sup> and

Ingle<sup>17</sup> have histological evidence showing that occlusal trauma causes pathological changes in the circulation of the periodontal tissues, pulpal tissues, and hard tissues. Bhaskar<sup>29</sup> found these changes to specifically be necrosis of periodontal tissues, resorption of bone, thrombosis, and resorption on the sides of pressure; widening of the periodontal membrane, root resorption, thrombosis, and bone formation on the sides of tension. All the above findings were in teeth without caries or otherwise complicated by open bacterial invasion of the pulp tissues. Orban,<sup>34</sup> Coolidge,<sup>35</sup> Stuteville, and Oppenheimer feel that injuries to the pulp caused by orthodontic treatment are the result of ischemia due to crushing, tearing, and obliterating vessels in the periapex. This may be accomplished by forceful intrusion, extrusion, or occlusal jiggling during mastication while teeth are loose concurrent with orthodontic movement.

### Compulsive Bruxing Vs. Pulp

Ingle<sup>17</sup> and Natkin<sup>19</sup> present eight cases of pulpal necrosis associated with compulsive bruxism. Unlike any of the experimental models referred to in previous literature, these patients were able to subdue logical conscious reflexes by the stronger subconscious desire to brux. It is interesting to note that all the individuals were females between the ages of 13 and 16 years old and had definite pressing family problems. The obvious question, "Why doesn't osteoporosis and pulpal death associated with compulsive bruxing occur in individuals over sixteen?" may be answered in part by Butcher and Taylor's work with monkeys. Upon intrusion of

incisors with closed apical foramina, the pulpal vessels were not strangulated but were protected by the thicker root ends and the more secure anchorage of the tooth in the alveolus. Intruded incisors with open foramina showed upon a histological sectioning ischemia and subsequent necrosis of pulpal tissues.

### Conclusion

1. Subjects interrelating occlusal adjustment and endodontics have been discussed: diagnosis of associated pain, the cracked tooth syndrome, periapical repair in the face of traumatic occlusion, pulpal cellular response to occlusal trauma, and circulatory changes of the periodontium and endodontium.

2. Direct invasion of bacteria into pulpal tissues will certainly decrease the prognosis of any of the above conditions.

3. The orthodontic literature supports the view that occlusal trauma will cause pathological changes in pulpal-tissues.

4. In the compulsive occlusal trauma cases, pulp necrosis and alveolar osteoporosis occur not infrequently.

5. Occlusal trauma associated with periodontal disease may cause direct invasion of the pulpal tissues via lateral canals.

### Summary

The general conclusion is that the non-compulsive occlusal trauma cases will not cause pulpal necrosis, but will cause pathological changes. Compulsive occlusal trauma can and will cause pulpal necrosis.

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# Gingival Inflammation Vs. Gingival Carcinoma\*

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THE most common pathological conditions encountered in the oral cavity involve the gingival and periodontal tissues. The great majority of these diseases are inflammatory in nature, however, the clinical picture of inflammation and neoplasia may be similar. Patient prognosis in these two conditions is significantly different and enforces the necessity for the dentist to maintain a high index of suspicion for carcinoma.<sup>9, 10</sup> Three patients with carcinoma of the gingiva have recently been seen at the Oral Cancer Detection Clinic (OCDC), University of North Carolina School of Dentistry. These cases illustrate important considerations when dealing with gingival disease especially when it does not respond to routine therapy, or when the patient has a previous history of oral carcinoma.

Case 1. This 59-year-old Caucasian female was referred to the OCDC for evaluation of ulceration and hyperkeratosis of the buccal and lingual gingiva in the mandibular molar and bicuspid area. The patient had been observed periodically by her physician since early 1966 when a "seed wart" in the left

posterior buccal mucosa was biopsied. This excised mass was reported as squamous cell carcinoma. At that time, a biopsy was also taken from an unrecorded site on the gingiva. This tissue was reported as "leukoplakia." During the intervening years, the patient was encouraged to see her local dentist but she had neglected to do so. By November 1969, the lesion in her buccal mucosa had recurred and presented as a 1 cm. ovoid raised white lesion with an ulcerated center. Surgery on this lesion in the buccal mucosa was performed in December 1969.

Her past medical history revealed that she was being treated for a duodenal ulcer. She also reported an allergy to penicillin. A family history of diabetes was also elicited. Upon questioning the patient, it was determined that she had been using snuff for over forty years. Although the left buccal mucosa was the preferred site for tobacco placement, the right side was used occasionally.

Examination of the head, face, and neck was negative as was inspection of the lips, tongue and palate. At the time of initial examination, twenty-eight teeth were present, and her oral hygiene was fair. Plaque-like white areas were present bilaterally in the buccal mucosa and

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mandibular mucobuccal fold. These plaques showed extensive folding and were soft to palpation. The plaque was thickened in several areas on the gingiva and portions of the left floor of the mouth (Figure 1). In two areas the gingiva was ulcerated and had a granular, erythematous base (Figure 2). In these areas, the gingiva was indurated and more firmly bound to the underlying alveolar bone than the surrounding gingival tissue. There was no radiographic evidence of bone destruction in the area.

The pathology report of tissue taken from the buccal gingiva indicated that there were cords and clusters of neoplastic squamous cells extending downward from the surface of the specimen. The cells were in disarray, forming vague whirls. The nuclei were pleomorphic, some having large pale staining nuclei with prominent nucleoli. The cytoplasm of the cells had indistinct margins, however, intercellular bridges could be distinguished in several areas. Few mitotic figures were present. A chronic inflammatory cell infiltrate surrounded the islands of neoplastic epithelium. Atypical squamous cells in hyperplastic mucosal epithelium were found adjacent to the teeth (Figure 3). After the diagnosis of well differentiated squamous cell carcinoma was made, block resection of the involved portion of the mandible was performed.

**Case 2.** This is an obese 84-year-old Caucasian female who presented with a chief complaint of a sore in her left cheek, present for approximately nine months. She had consulted her local physician about this "ulcer" and he had treated her symptomatically without success for



Figure 1. White plaques on lingual gingiva and floor of the mouth.



Figure 2. White plaques and ulceration of the gingiva.

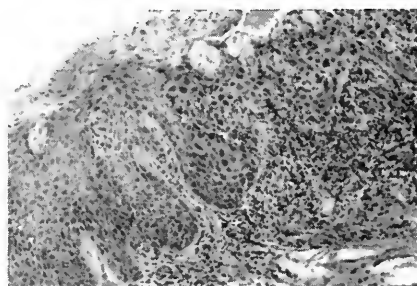


Figure 3. Pleomorphism and hyperchromatism.

over seven months. During that time, the lesion continued to enlarge and became painful. The patient was then referred to her local dentist for extraction of teeth

which the physician felt could have been traumatizing the areas in her left buccal mucosa. At the initial examination the dentist noted, in addition to the mass in the buccal mucosa, extensive white plaques on the gingiva and a 2 cm. x 7 mm. rough mass extending across the lingual frenulum in the floor of the mouth.

Past medical history revealed that the patient had high blood pressure for which she is receiving medication. Approximately three years ago she was hospitalized for intestinal obstruction. The patient has used snuff in the left vestibule for many years and doesn't remember when she began to use snuff. She has begun placing the snuff in the right side since the left cheek has been sore.

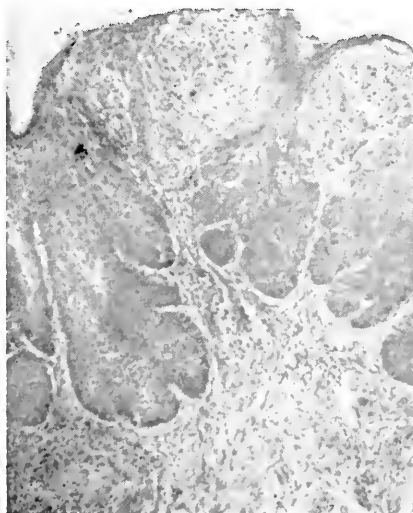
Examination of the head and neck revealed enlarged submandibular lymph nodes. These lymph nodes were firm but not fixed to the underlying tissue. Examination of the lips were within normal limits. Introrally, there was a firm raised 3x2 cm. ovoid pink and white nodule in the left buccal mucosa. Immediately posterior to this nodule a 1x1 cm. nodule was present. These lesions had raised, rolled borders and granular surfaces and were fixed to the underlying tissues. The mucosa of the lower lips demonstrated diffuse clinical leukoplakia. To the right of the midline in the labial mucosa, this clinical leukoplakia was piled up and firm. The right buccal mucosa contained diffuse areas of clinical leukoplakia as did the mandibular and maxillary gingiva. Twelve anterior teeth were present. The gingiva surrounding the mandibular teeth was erythematous and appeared swollen in the at-



Figure 4. Erythema and clinical leukoplakia of the gingiva.

tached gingiva area. Immediately beneath this area the attached gingiva was surfaced by thick white plaques which were firmly adherent to the underlying tissue (Figure 4). Incisional biopsy of the lesion in the buccal mucosa and lesion in the floor of the mouth both showed well differentiated squamous cell carcinoma. The treatment of choice for this patient consisted of removal of the remaining teeth followed by radiation therapy. During removal of the teeth, biopsy specimens from

Figure 5. Early invasive squamous cell carcinoma.



the gingiva were submitted. Histo-pathological studies found the specimens to be irregular fragments of soft tissue surfaced in part by stratified squamous epithelium which is parakeratotic in some areas and keratinized in other areas. In one area of the specimen there is thinning of the epithelium, and presence of irregular rete ridge proliferation into the underlying connective tissue. These irregular rete ridges show loss of basal orientation, hyperchromatism, and pleomorphism of the epithelial cells (Figure 5). Small nests of neoplastic epithelial cells have separated from the surface epithelium. The submucosa throughout the specimen is infiltrated with chronic inflammatory cells.

At the completion of the radiation therapy, radiation mucositis was present and there had been regression of all of the lesions. Follow-up has been too short for thorough evaluation.

Case 3. This patient is a 66-year-old Negro female who reported good dental health until March 1969, when she began to develop soreness of the lower right posterior gingiva. At that time she was seen by her dentist who extracted two periodontally involved teeth in the area of soreness. She continued to have intermittent soreness of the gingiva until September 1970 when she again sought treatment. Because the area appeared to be inflamed, antibiotics and thorough scaling were utilized. This therapy was unsuccessful so the patient was referred to the Oral Cancer Detection Clinic.

Past medical history and family history contributed no pertinent information. She seldom smokes cigarettes and reports no history of



Figure 6. Slightly elevated gingiva of cuspid.

snuff usage or consumption of alcoholic beverages. Head and neck examination revealed multiple sebaceous adenomas on the upper portions of the face. Observation and palpation of other head and neck structures were within normal limits. Lips, dorsal surface of the tongue, palate and oropharynx revealed no significant pathology. The right buccal mucosa and muco-buccal fold contained diffuse areas of ulceration and hyperkeratosis. On the edentulous right mandibular ridge in the bicuspid and molar region, there was a slightly elevated erythematous area which was sensitive to palpation. This change extended anteriorly to include the gingiva of the cuspid tooth (Figure 6). In the left posterior floor of the mouth and lingual of the alveolar ridge there was a linear hyperkeratotic area approximately 2x1 cm. Diffuse areas of hyperkeratosis were also present in the left buccal mucosa, mandibular vestibule and right ventral surface of the tongue.

Biopsy of the right mandibular gingiva and alveolar mucosa revealed a surface provided by keratinized squamous epithelium which is typical of gingiva epithelium. In other areas there is a break in the continuity of the gingiva and in these

areas the epithelial surface demonstrates alternating keratinization, parakeratosis and ulceration. The epithelial cells are undergoing extreme degrees of hyperplasia and anaplasia. Nests of neoplastic epithelial cells are present in the submucosa. These nests contain hyperchromatic cells, some of which are vacuolated while others are forming keratin. This is the microscopic picture of squamous cell carcinoma.

This patient has received cobalt radiation therapy. Follow-up examinations for six months have shown no evidence of tumor and no dental complications.

*Discussions:* "The similarity of early cancerous lesions of the gingiva to common dental infections has frequently led to delay in diagnosis or even to misdiagnosis."<sup>7</sup> Two of these three patients were receiving professional care frequently, however, the changes on the gingiva had been attributed to longstanding inflammation. As illustrated by these cases, cancer of the gingiva is more frequently ulcerative than exophytic in growth pattern.<sup>3</sup> This variation in appearance has caused confusion with conditions such as periodontics, dental abscess, denture irritation, giant cell reparative granulomas, and other benign tumors or inflammatory conditions. Such a varied clinical appearance dictates biopsy of the gingival tissues.

All three of these patients showed varying areas of clinical leukoplakia. Although it is well recognized that many white lesions are pre-malignant, all too frequently a biopsy and sufficient follow-up is not performed. Until a definitive diagnosis is made, continued observation or local therapy can only result in delay of proper treatment and a poorer

prognosis for the patient. The statistics of Cady and Catlin<sup>2</sup> illustrating the difference in 5-year survival between localized and disseminated disease must be emphasized.

Radiographic evidence of bony invasion by malignant cells was lacking in each of these three cases. Panagopoulos<sup>5</sup> however, states that bone invasion microscopically is more frequent than indicated by radiograph. Since gingival cancer involves bone very early in its course, treatment is difficult and subsequent prognosis is guarded. In larger series, the prognosis varies from 30-50 per cent for five year survival.<sup>3, 8, 11</sup> As in all malignant diseases, early diagnosis is of extreme importance. Despite the fact that gingival cancer may be ulcerative or well defined in papillomatous, late detection is frequent. Soreness, the most frequent complaint of patients, occurs in approximately 20 per cent of the cases.<sup>4</sup> Often gingival cancer is associated with pain and mobility of a tooth. When this tooth is extracted, the first indication that something other than the inflammation is responsible for these symptoms is the proliferation of the cancer from the extraction site.<sup>3</sup> Pain was the initial complaint of only one of these patients. Even with extensive areas of involvement, pain was not present in the other two patients.

A complete history is often helpful in suggesting the correct diagnosis. The patients presented here all are over 50 years of age, an age when cancer incidence becomes increased. Two of the three have used snuff for extended periods of time. Snuff has been implicated as an etiological agent by many authors.<sup>1, 6, 9</sup> Squamous cell car-

cinoma of the gingiva has been reported to occur at an earlier age in females than in males. A reasonable explanation might be the widespread use of snuff by females in some population groups. It has been suggested by Thompson<sup>10</sup> and Brown<sup>1</sup> that oral cancer has a higher overall incidence and a greater frequency in women in the southeastern United States than in other parts of the country.

It is also important to note that multiple sites of origin for intraoral squamous cell carcinoma is not uncommon. In two of these cases, the previous diagnosis of carcinoma and the history of snuff usage for extended periods should alert the practitioner to the possibility of any gingival lesion being squamous cell carcinoma.

Treatment of gingival carcinoma utilizes surgical and radiation therapy techniques often in combination. Follow-up time in each of these patients has been insufficient to thoroughly evaluate their treatment.

*Summary:* Because of the similarity in appearance between gingival inflammation and gingival carci-

noma, microscopic examination of gingival tissue should be utilized in reaching a definitive diagnosis. As illustrated by these three cases, the presence of bone resorption and pain are variable and unreliable indicators of gingival carcinoma. Age, sex, geographic location, snuff usage, and a history of other intraoral primary carcinomas should motivate the practitioner to pursue a differential diagnosis which includes gingival carcinoma.

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# Results of Survey by Board of Dental Examiners

*The North Carolina Board of Dental Examiners recently conducted a survey on vital problems facing the profession in North Carolina. The editors feel that the results are interesting and are presented here for the benefit of the membership.*

1. Do you favor licensure examination for all dental graduates? Yes 1069  
No 220

2. Should North Carolina continue to accept the results of the National Board written examination? Yes 1126 No 97

3. Should the North Carolina State Board of Dental Examiners require proof of continuing education as a requirement for license renewal? Yes 665 No 588

4. Should the state society or constituent societies require proof of continuing education as a requirement for membership? Yes 512 No 697

5. Should the dental profession support federal control of dental licensure? Yes 153 No 1124

6. Should dental licensure be controlled at the individual state level? Yes 1109 No 150

7. Should North Carolina have reciprocity with other states, i.e., any dentist licensed in another state could practice in North Carolina with no examination and vice versa? Yes 635 No 632

8. Would a Regional Board for the Southeastern states be preferable to an individual State Board? Yes 458 No 755

9. If North Carolina entered into a discussion of a cooperative licensing effort with Virginia and South Carolina, which would you prefer? Total answering 1239

a. Regional exam 232

b. Reciprocity 642

a. North Carolina license only those who pass the North Carolina Board examinations 365

10. Should an applicant for licensure in North Carolina be granted a license solely on proof of having been graduated from an accredited dental school, that is, without a licensure examination? Yes 231 No 995

11. Should graduates of foreign dental schools be considered to have qualifications equal to graduates of American schools when applying for dental license? Yes 214 No 1045

12. Should qualified specialists have a separate and different examination from the regular State Board examination for general dentists? Yes 843 No 358

13. Should a qualified specialist have a North Carolina license to practice general dentistry before being granted a license to practice his specialty? Yes 650 No 605

14. Do you think Dental Hygienists could and should be trained to perform these duties: (check the duties you prefer). Total answers 1248

- a. soft tissue curettage 744
- b. administer local anesthesia 292
- c. place sutures 265
- d. deep scaling and root planing 788
- e. preliminary impressions 835

15. Do you think Dental Assistants could and should be trained to perform these duties: (check the duties you prefer). Total answers 1248

- a. place and remove matrix bands 665
- b. condense alloy fillings 386
- c. carve alloy fillings 360
- d. place and finish silicate and resin fillings 317
- e. polish alloy fillings 785
- f. pumice prophylaxis 840
- g. preliminary impressions 839

16. Should dental auxiliaries be trained to perform these functions in: (check the training method you prefer). Total answers 1267

- a. formal programs as they now exist 362
- b. preceptorship (in the dental office by the dentist) 159
- c. combination of the above 746

17. Do you think the Dental Practice Act of the General Statutes of North Carolina should be changed at this time to allow dental auxiliaries to perform services for the patient which are now defined as Dentistry? Yes 746 No 476

# Items of Interest

## Three Dental Schools Shorten Curriculums

The dental schools at the University of Pittsburgh, the College of Medicine and Dentistry of New Jersey, and the Medical College of Georgia have shortened their curriculums to three years.

The New Jersey program compresses four academic years into three calendar years, with each academic year consisting of three eleven-week trimesters.

At Georgia a twelve-quarter curriculum has been initiated which students will complete in three calendar years.

The Pittsburgh plan actually allows outstanding students to graduate after three academic years of normal length. This is made possible by a fourth-year curriculum which is completely elective and devoted to "an expansion of professional competence."

## New Slide Talk Made Available

A new slide talk produced jointly by the American Pharmaceutical Association and the American Dental Association is now available for meetings of pharmacists and dentists.

The 20-minute, 78-slide program entitled "The Dentist, The Pharmacist and Oral Health," describes oral hygiene products such as toothbrushes, dentifrices, denture adhesives, reliners, aspirin and other medicaments plus giving a brief review of the oral cavity, its structure and associated diseases.

The script provides for a joint presentation by a pharmacist and a dentist, each having a speaking part. It also can be presented by one practitioner. The 35 millimeter slides are in color and include drawings and photographs. Some 100 leaflets accompany each slide kit for distribution to the audience.

Loan requests for the program should be directed to the Order Desk, American Pharmaceutical Association, 2215 Constitution Ave., N.W., Washington, D. C. 20037.

## 63 Disadvantaged Minority Students Awarded Scholarships

Sixty-three disadvantaged minority students have been awarded dental scholarships for the 1971-72 school year by the American Fund for Dental Education.

The 1971 awards represent a 55 percent increase in the number of scholarships awarded last year.

Commented Clifton O. Dummett, D.D.S., Chairman of the Awards Committee: "This year we were very pleased to be able to award 22 more scholarships than the 40 awarded last year, due to increased support from foundations and other sources."

## L. M. Anderson, Jr., Honored

L. M. Anderson, Jr., chairman of the board, Decoa, Inc., Tampa, Fla., and a director of the American Fund for Dental Education, has received the 1971 Award of Recognition of the American Society of Dentistry for Children.

The award was presented to Mr.

Anderson during the ASDC's recent annual meeting in Atlantic City, N. J.

In presenting the award ASDC President-Elect Roy L. Lindahl cited Mr. Anderson's many contributions to the dental care of children.

The ASDC award is made each year to a non-dentist for outstanding contributions in support of children's dental health.

## **Relief Fund Campaign Underway**

The annual Relief Fund appeal letters are in the mails and the 1971-72 Relief Fund Campaign is underway. The quota for the N. C. Dental Society is \$1,840.00.

Doctor Carl A. Laughlin, president of the American Dental Association, has asked all ADA members to contribute as generously as possible this year to meet anticipated requirements.

In the past two years, the Relief Fund contributions have fallen short of the \$125,000 campaign goal. The ADA Council on Relief raised the campaign goal of \$125,000 in 1960. That goal was surpassed in seven campaign years during the past decade, but not during the last two.

Last year, dentists throughout the country contributed about \$122,000 of which a majority of the funds was returned to the state dental society relief funds. Dentists in North Carolina contributed \$2,218.00 to the fund.

Three-fourths of the money received from each state is automatically returned to the constituent society at the end of the campaign year. The entire amount can be returned to the state if that state has attained its individual quota and if

the state has paid out in shared grants a sum greater than was received as a regular refund.

## **Court Bars Move to Drop Dental Care**

A federal court has temporarily barred the State of New York from eliminating dental care benefits from its Medicaid program.

In a move to reduce Medicaid costs, the state legislature earlier this year approved the elimination of dental benefits for all 660,000 assistance recipients. Also to be eliminated were payments for prescription drugs, physical therapy, eyeglasses and some other services. In addition, some 165,000 of those recipients would have been removed from the Medicaid roles completely by a tightening of the eligibility standards.

The first legal challenge to the proposed eliminations and cutbacks was initiated last May, but it failed. The current lawsuit contends that recent social security laws bar the state legislature from reducing the scope of the federally assisted Medicaid program. New York City has made a motion to intervene in the suit to add the city's support to the challenge to the state's proposed cutbacks.

## **ADA Issues Statement On Mercury**

In view of the widespread interest in mercury the ADA's Council on Dental Materials and Devices and the Council on Dental Research sponsored a review article on the significance of mercury used in dental practice. This was published in the June 1971 issue of *The Journal of the American Dental Association*.

The review indicates there is no contamination of the environment if proper office procedures are followed and if scrap amalgam is collected and salvaged. The review concludes that proper mercury hygiene minimizes any possible danger to dental personnel. There is emphasis, however, on the importance for the profession to evaluate dental procedures from time to time as new information becomes available on the physiological significance of increased exposure to mercury from all sources.

### **ADTA Contributions Exceed \$2 Million**

Alvin L. Morris, D.D.S., Ph.D., president of the American Fund for Dental Education, presented an Honor Award Oct. 11 to the American Dental Trade Association in recognition of ADTA's having contributed more than \$2 million to AFDE.

A plaque citing ADTA for "distinguished service to dental education" was accepted by Herbert L. Myers, ADTA president, during the 1971 Annual Session of the American Dental Association in Atlantic City.

In presenting the award Dr. Morris declared, "The American Dental Trade Association and its member companies have been one of the strongest supporters of the Fund ever since its inception. During the past 10 years the ADTA has provided more than 38 per cent of the

total support we have received. We look forward to the continued generous support of this important member of the dental health team for the good of dental education and the profession, itself."

### **ADA Studies Registry for Continuing Education**

The feasibility of establishing an ADA Registry for Continuing Education will be learned in a pilot program with the states of Minnesota and Kentucky. The ADA Council on Dental Education will utilize the Association's computer to record all continuing education courses taken by persons licensed by these two states.

Funded by a \$46,900 grant from the ADA Foundation, the Council will record course credits for each dentist and provide computer print-out summaries upon request from the states. The state boards of dentistry will then evaluate the courses taken by each individual in meeting his requirement for relicensure.

The Registry project itself is not designed to evaluate or accredit the courses, but rather will serve as a clearing house for information on credits earned by practitioners.

If the pilot project proves to be effective, it will be made available to all states, providing them with an economical and easily accessible listing of the continuing education taken by its licentiates residing in and out of the state.

# Continuing Education in Dentistry

**The Medical College of Georgia  
School of Dentistry  
Augusta, Ga. 30904**

**ORAL PATHOLOGY, January 19,  
1972**

Dr. Charles A. Waldron  
Limited to 18 enrollees  
Fee \$35.00

**THE DENTIST'S PERSONAL  
HEALTH, February 4, 1972**

Robert J. Samp, M.D. and Mrs.  
Samp  
Fee \$35.00 (includes the den-  
tist, his wife and staff)

**PERIODONTAL PROSTHESIS,  
February 12-19**

Drs. Billy M. Pennel and Da-  
vid E. Beaudreau  
Cruise seminar to San Juan  
Fee \$75.00 plus passage

**CONTEMPORARY PROBLEMS  
IN ORAL SURGERY, Febru-  
ary 15-16, 1972**

Dr. Daniel E. Waite  
Fee \$75.00

**ORTHODONTICS, February 21-  
25, 1972**

Dr. Eugene D. Voth  
Cruise seminar to Key West  
Limited to orthodontists  
Fee \$75.00 plus passage

**OCCCLUSION, April 27-28, 1972**

Dr. Harry C. Lundeen  
Fee \$75.00

**MODERN DENTAL PRACTICE  
CONCEPTS AND PROCE-  
DURES, May 19-20, 1972**

Dr. Lloyd N. Hollander  
Fee \$90.00 (includes dentist and  
his staff)

**Northwestern University Dental  
School**

**311 E. Chicago Avenue  
Chicago, Illinois 60611**

**COMPLETE DENTURE REVIEW  
FOR GENERAL PRACTI-  
TIONERS, May 4-5, 1972**

Dr. Bernard Levin  
Fee \$100.00

**NON-PARALLEL RETAINERS  
FOR PERIODONTALLY IN-  
VOLVED TEETH, May 16  
and 18, 1972**

Dr. Saul M. Hirschberg  
Limited to 10 enrollees  
Fee \$100.00

**BASIC PERIODONTICS, March  
29, 1972**

Drs. Leon D. Rosenfield, Saul M.  
Hirschberg, and Kenneth A.  
Krebbs

Limited to 8 enrollees  
Fee \$150.00

**University of Pennsylvania  
School of Dental Medicine  
4001 Spruce Street  
Philadelphia, Pa. 19104**

**OCCCLUSION AND THE RA-  
TIONALE OF IMPLANTS  
BLADES AND SUBPERIO-  
STEAL, February 2, 1972**

Dr. Aaron Gershkoff

**PAIN, CLICKING AND LIMITA-  
TIONS IN MANDIBULAR  
MOVEMENTS, February 7-8,  
1972**

Dr. Marvin A. Alderman

REFRESHER COURSE IN PERIODONTAL THERAPY, February 19, 1972

Drs. D. Walter Cohen and Morton Amsterdam

PERIODONTAL PROSTHESIS, February 21-25, 1972

Drs. Morton Amsterdam, D. Walter Cohen and associates

DENTO - FACIAL ORTHOPEDICS, February 28 - March 2, 1972

Dr. Viken Sassouni

MOLAR ENDODONTICS, March 6-10, 1972

Drs. Louis I. Grossman, Seymour Oliet and George G. Stewart

REFRESHER COURSE: ADULT TOOTH MOVEMENT IN COMPREHENSIVE DENTISTRY, March 15, 1972

Drs. Manuel H. Marks, Herman Corn and I. Stephen Brown

GETTING PREVENTION THROUGH TO YOUR PATIENTS, March 1, 1972

Dr. Jerome S. Mittelman

MODERN RESTORATIVE DENTISTRY WITH FIXED AND REMOVABLE PARTIAL DENTURES, March 16-17, 1972

Dr. Lawrence H. Clayman

PROCEDURES IN RESTORATIVE DENTISTRY, March 17-18, 1972

Dr. Frank V. Celenza

THE CROZAT APPLIANCE AND TECHNIQUE, March 27 - 29, 1972

Dr. Samuel D. Gore, Jr.

FIXED BRIDGEWORK IN GENERAL PRACTICE, March 27-30, 1972

Lecture, demonstration and participation

Dr. Charles B. Sceia

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ADVANCED CLINICAL PATHOLOGY OF THE ORAL REGIONS, February 7-11, 1972

PERIODONTICS, March 13-17, 1972

ORAL DIAGNOSIS AND THERAPEUTICS, April 17-21, 1972

# North Carolina Dental Assistants Association



The North Carolina Dental Assistants Association sent 9 delegates and 2 clinicians to the American Dental Assistants Association 47th Annual Session, October 10-14, at the Claridge Hotel in Atlantic City.

Delegates representing NCDAA were: Aileen Croom, Wilmington, President; Wilma Wilson, Lexington, President-Elect; Linda Heffinger, Eden, Vice President; Betty Scott, Goldsboro, Secretary; Cheryl Kearney, Snow Hill Treasurer; Joyce Lawson, High Point; Doris Hiatt, Greensboro; Ethel Earl, Efland; and Martha Wilson, Wilmington.

Diane Langevin and Linda Hamrick, Charlotte, went as clinicians and presented their award-winning clinic "Effective, Efficient Charting of the Teeth."

Highlights of the annual meeting included:

—Discussion on continuing education presented by the Education Committee of the ADAA, and an open forum on revisions presented by the Special Bylaws Revision Committee.

—Dr. C. W. Gilman, Keynote speaker, "ADAA in a Changing Health Care System." The ADAA President, Myra Petrie of Sewickley, Pennsylvania, presided over the meeting.

—Education meetings on: Chairside Assisting, Office Management, Patient Education and Career Mobility within the Oral Health Care Delivery Team.

North Carolina Dental Assistants Association received Third Place award for the association showing the largest numerical increase in membership since the close of the last membership year, and First Place News Bulletin Award. This award is presented to the state association submitting the most informative and educational news bulletin with membership over 300.

Reandy Clement of Raleigh served as a page for the House of Delegates Meetings.

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# District News

## FIRST DISTRICT

JOE B. ROBERSON, *Editor*

The First District Dental Society convened for its 50th annual meeting at the Green Park Hotel in Blowing Rock, October 2, 1971. A total of 137 dentists attended the three-day meeting, including 118 members.

Thirteen new members were elected and inducted. They were charged by Dr. S. Ecerett Moser, a past president of the North Carolina Dental Society and were presented new member kits prepared by the Central Office staff.

A memorial service was conducted by Dr. Pearce Roberts, Jr. for the following members who had died during the past year: Drs. P. P. Yates, Lenoir; George Patterson, Asheville; Walter E. Furr, Franklin; C. T. Brown, Hickory; and J. L. Woody, Bryson City.

Dr. Fred N. Ogden, II was installed as president for 1971-72. Other officers elected and installed included Dr. D. F. Hord, president-elect; Dr. Carey T. Wells, Jr., vice president; Franklin E. Martin, secretary-treasurer; Dr. Joe B. Roberson, editor; Dr. Francis A. Buchanan and Dr. Robert B. Litton, delegates; and Dr. William A. Current, member of the Executive Committee.

In general session, the Society amended its *Bylaws* authorizing the Executive Committee to accept new members by majority vote any time during the year and not just at the annual meeting.

## SECOND DISTRICT

DONALD D. CULP, *Editor*

Dr. William H. Price of Monroe was installed as president of the



FIRST DISTRICT OFFICERS 1971-72 (l to r): Dr. D. F. Hord, president-elect; Dr. Fred N. Ogden II, president; Dr. Franklin E. Martin, secretary-treasurer; Dr. Francis A. Buchanan, delegate; Dr. Joe B. Roberson, editor; Dr. William A. Current, member of the Executive Committee; Dr. Carey T. Wells, Jr., vice president.

Second District Dental Society at its annual meeting in Winston-Salem at Hilton Inn, September 12-14. Other officers elected and installed were: Dr. Keith L. Bentley, North Wilkesboro, president-elect; Dr. Frank H. Daniel, Winston-Salem, vice president; Dr. Kenneth W. Owen, Charlotte, secretary-treasurer; and Dr. James D. Blankenbeckler, Winston-Salem, editor.

The Society elected thirteen new members and amended its *Bylaws* granting authority to the Executive Committee to elect new members by majority vote.

## THIRD DISTRICT

RICHARD M. FIELDS, *Editor*

The Third District Dental Society held its annual meeting at Holiday Inn Four Seasons in Greensboro, October 2-4.

On Saturday afternoon Dr. C. W. Poindexter of Greensboro moderated a forum on The Changing Dental Practice. The forum was concluded on Sunday morning.

Saturday night was Monte Carlo night, featuring black jack, crap and roulette tables. The evening was climaxed by an auction for door prizes in which the Monte Carlo winners participated in the bidding.

Dr. Charles W. Jarvis, a professional after-dinner speaker and humorist, as well as a practicing dentist, was the speaker at Sunday night's banquet.

Dr. Milton Siskin, professor of endodontics at the University of Tennessee, was the clinician for the meeting.

At the General Session the *By-laws* were amended to permit the Executive Committee to elect new members.

Officers elected and installed for the coming year include: Dr. Leonard R. Cashion, president; Dr. Joseph R. Suggs, president-elect; Dr. Charles A. Reap, Jr., vice president; and Dr. Richard M. Fields, secretary-treasurer.

Thirty-five new members were elected and inducted.

## FOURTH DISTRICT

RICHARD S. HUNTER, *Editor*

The Fourth District Dental Society held its 51st annual meeting October 23-25, 1971, at the Holiday Inn on Hillsboro Street in Raleigh.

On Saturday night a cocktail party on the top floor of the building gave the group a beautiful panorama banquet. Dewey Huffines and the popular quartet, "The Capatones," entertained the members, wives and guests. A young band featuring "big band, old time sound" was particularly enjoyed by the group.

The golfing segment of the Society enjoyed a tournament Sunday morning.



THIRD DISTRICT OFFICERS 1971-72. Dr. James B. Howell (third from left) retiring president, congratulates Dr. Leonard R. Cashion upon his election as president. Other new officers installed for 1971-72 are (from left to right): Dr. Guy R. Willis, delegate; Dr. Richard M. Fields, secretary-treasurer; Dr. Charles A. Reap, Jr., vice president; and Dr. Joseph R. Suggs, president-elect.

A new member luncheon was followed by an outstanding address by Mr. Edward W. Hiles. His address was entitled "What's Happened to the Spirit of America?" It is hoped that it may be published later in the *JOURNAL OF THE NORTH CAROLINA DENTAL SOCIETY*.

The general session was presided over by Dr. D. W. Seifert. The president's address was well re-



FOURTH DISTRICT OFFICERS 1971-72: (l to r) Dr. James H. Edwards, Raleigh, president; Dr. Norman B. Grantham, Smithfield, vice president; Dr. Mitchell W. Wallace, Spring Lake, secretary-treasurer; Dr. D. W. Seifert, Raleigh, retiring president; Frederick G. Gasty, Fayetteville, president-elect. Not in picture: Dr. Richard S. Hunter, Raleigh, editor.

ceived. After the nominating committee report by Dr. W. H. Oliver, the following officers for 1971-1972 were elected: Dr. James H. Edwards, president; Dr. Fred G. Hasty, president-elect; Dr. Norman B. Grantham, vice president; Dr. Mitchell W. Wallace, secretary-treasurer; Dr. Richard S. Hunter, Editor.

A social hour was later enjoyed by the members, wives, and guests Sunday night.

Dr. Frederick J. Stare of the Nutrition Department of Harvard University presented the lecture Monday morning. A large audience received his presentation on "Nutrition for Better Health" very well. He stated that in his opinion fluoridation of public drinking water was the greatest public health measure ever instituted.

An unusually good group of table clinics were enjoyed by the members before noon. Dr. Kenneth L. Johnson did an outstanding job in arranging such a large number of worthwhile clinics.

The afternoon session was technical in nature and superbly presented by Dr. Nelson W. Rupp of the National Bureau of Standards. His subject was "Findings on the Newer Dental Materials." An excellent question and answer period followed the lecture.

## FIFTH DISTRICT

GARLAND R. HOMES, *Editor*

The Fifth District Dental Society held its largest meeting ever at the Blockade Runner in Wrightsville Beach, North Carolina, September 16-18, 1971.

Dr. James Privette of Kinston was installed as president. Other officers elected and installed were Dr.

William E. Kidd of Washington, president-elect; Dr. Wayne Anderson of Jacksonville, vice president; and Dr. David Freshwater of Morehead City, secretary-treasurer.

Dr. Walter Linville presided at an informative and enjoyable meeting. Once again the arrangements were the responsibility of Drs. Wayne Anderson and Will Hinnant and the membership expressed thanks to them for their untiring efforts.

Highlight of the occasion was an oceanside dance on the patio of the Blockade Runner, Friday night.

Dr. Paul Jacobi presented a practice administration clinic to overflow crowds, attended by dentists, wives and auxiliaries.

In general session the Society passed unanimously a resolution that the Dental Practice Act be amended to require continuing education for renewal of license to practice dentistry in North Carolina.

Dr. M. W. Aldridge was unanimously endorsed as the district candidate for delegate to ADA.

A resolution was adopted honoring Dr. Paul E. Jones of Farmville for his distinguished service as a delegate to the ADA covering a span of 40 years. Dr. Jones was first elected a delegate in 1931.

In further business, the District amended its *Bylaws* to permit the executive committee to elect new members.

On Saturday the Society enjoyed a new format with projected table clinics presented by Dr. Lyle E. Crumpler, Dr. C. B. Smith, Drs. A. J. Bullard and Douglas Hill, Dr. William E. Kidd, and Dr. H. Wayne Ridout.

Fourteen dentists were elected to membership.

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	Under 30	30-39	40-49	50-59	60-69
\$300.00	\$148.50	\$169.50	\$244.50	\$340.50	\$421.50
250.00	124.50	142.00	204.50	284.50	352.00
200.00	100.50	114.50	164.50	228.50	282.50
150.00	76.50	87.00	124.50	172.50	213.00

Plan L-65		Maximum Accident Benefits Lifetime	Maximum Sickness Benefits To Age 65			
Weekly Benefits		SEMI-ANNUAL RATES				
	Under 30	30-39	40-49	50-59	60-69	
\$300.00	\$184.50	\$211.50	\$289.50	\$388.50	\$421.50	
250.00	154.50	177.00	242.00	324.50	352.00	
200.00	124.50	142.50	194.50	260.50	282.50	
150.00	94.50	108.00	147.00	196.50	213.00	

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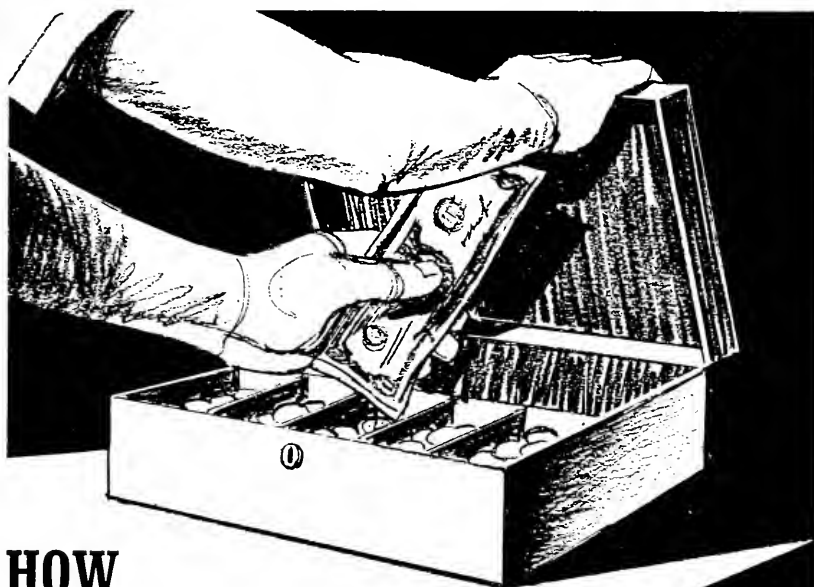
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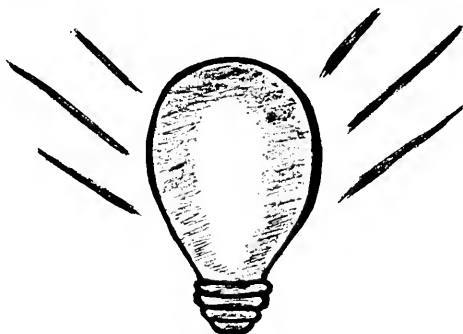
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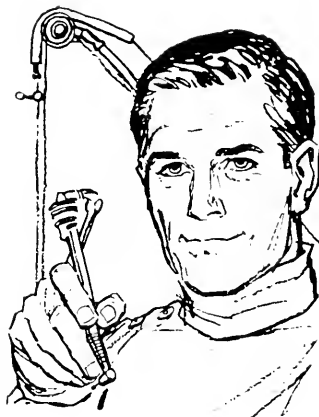
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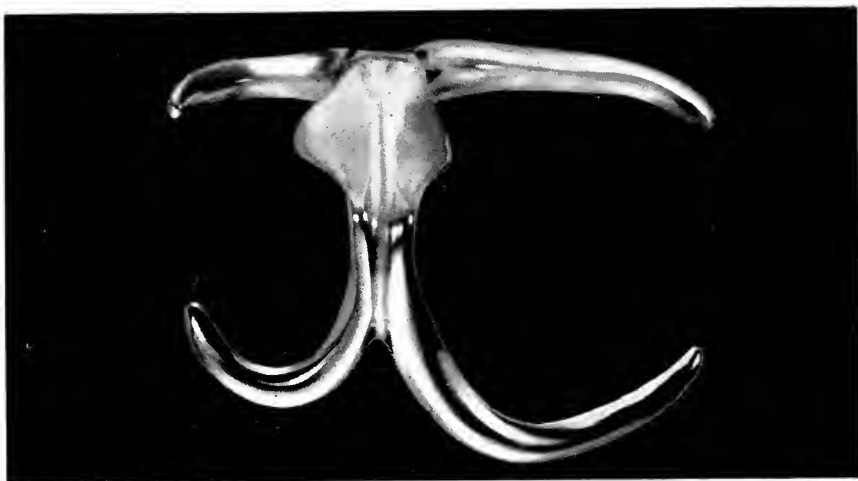
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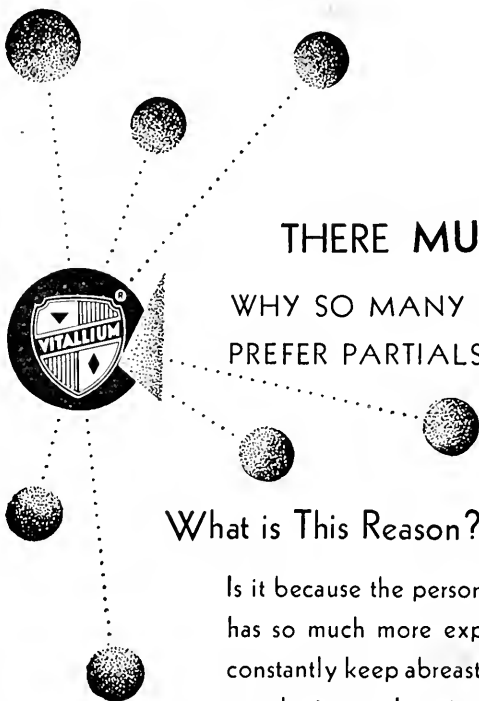
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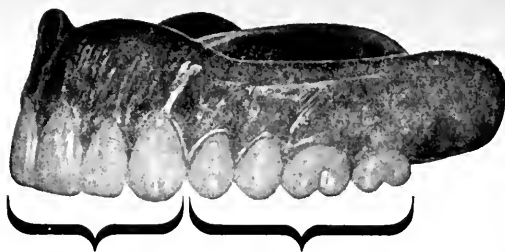
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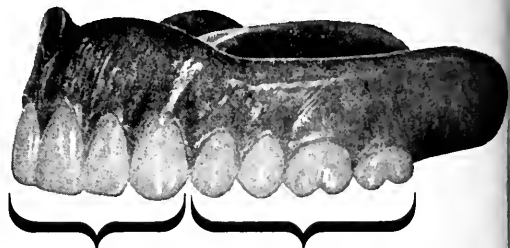
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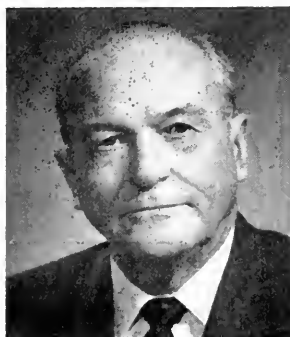
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# The President's Page



MEMBERSHIP in organized dentistry gives certain privileges and exacts corresponding responsibilities. It affords the opportunity to enjoy a firmly established reputation of the finest traditions in professional relationship, and each of us must accept the responsibility not only to maintain this high level, but to further develop it into greater areas of usefulness for the betterment of Society and for the advancement of the profession.

We in North Carolina dentistry enjoy an enviable personal and professional relationship, that was developed and nurtured by those who preceded us — men of dedication, of unselfish impulses, and great minds. The image of dentistry, that has been created in the many years gone by, challenges each of us to diligently, faithfully, and honestly continue the desire to expand this image and meet the needs and demands for advancement and improvement necessary to overcome

the increasing threats to the profession.

The actions of the 1972 House of Delegates will give impetus to the future progress of dentistry in North Carolina. We will welcome, as ex-offices members, to the House of Delegates, two students from each class of our UNC School of Dentistry. These future members of dentistry need to be introduced to the problems facing the profession and especially since their professional lives, in a great measure, will be determined by how the profession resolves the present impact of demand and threat to the profession.

Much effort, time, and thought has been given by many fine individuals to make the 116th Annual Session informative, interesting, and enjoyable. The present and the emerging profession needs your guidance, your presence, your opinions, and your support.

Welcome to the Annual Session.

WADE H. BREELAND

# **Delta Dental Plans Association and Dental Service Plans Insurance Co.**

*The editor believes that a more complete understanding of the Delta Dental system both state and national is of the utmost importance. In view of the many questions asked by members of the NCDS about Delta Dental Plans and Dental Service Plans Insurance Company, the following letters serve to explain how these programs are beneficial to dentistry at large and especially to the NCDS as soon as we have our own plan operational. The letters are explanatory and expository about Delta Dental and should be read with care by all members of NCDS for better information.*

Dear Andy:

In reviewing my letter of January 18, 1972 to you concerning the purchase of stock in the Dental Service Plans Insurance Company, I noted I had neglected to include a few other comments on reasons why the North Carolina Plan and society should be concerned with the successful capitalization of the company, and I wanted to add these to my previous comments.

From the viewpoint of complete enlightened self-interest, I believe that the organized profession in your state might well see the value of becoming shareholders in the Dental Service Plans Insurance Company and having that company admitted to do business in the State of North Carolina. For purely selfish reasons, the Delta Dental Plan of North Carolina, until such time as it is able to acquire authority to underwrite programs in your state, might well use the DSPIC to assume risks in connection with programs generating within the state or with respect to multistate programs originating elsewhere.

At some point in the future, when the North Carolina Plan has a fully self-sufficient underwriting base, there are very likely to be situations in view of the growing industrialization in your state whereby programs may originate involving the provision of coverage for employees of the North Carolina headquartered company who are based in such states as South Carolina and Georgia, where the local Plans by statute can only administer and not underwrite. This again would be an occasion where DSPIC could enter the picture and provide the underwriting for the programs with administration handled by the South Carolina and Georgia Plans under the direction of the North Carolina Plan as Control Plan for the program.

With the anticipated growth of Delta programs both on a national and intrastate basis forecasted in the next few years throughout the east and the new part of the southeast, there are many sound reasons why the Delta system has a strong need for a national underwriting entity to backup its efforts in representing the profession through dental society sponsored prepayment Plans. As in other forms of marketing and merchandising, it is expected that the wider the circulation that the Delta name and symbol

achieves as representative of a provider-sponsored prepayment system, the faster the rate of growth of programs that vary in sizes within a particular state and in the states adjoining it. This has certainly been true in the western United States, is becoming evident in the midwest and eastern states and will, predictably, be happening in your area also within the very near future.

I hoped these additional comments when added to my earlier remarks will be of assistance to you, Glen and Roy, in your efforts to achieve both moral and financial support for the service Plan concept and for the Dental Service Plans Insurance Company from the profession in your state.

—JAMES BONK, Director  
Enrollment and Plan Services

---

Dear Andy:

In response to your recent conversation with Mr. Lassiter, he asked that I send to you a collection of materials related to the formation and activation of the Dental Service Plans Insurance Co., the stock insurance company formed to serve as an adjunct to the Delta Dental Plan system. I am enclosing copies, as well as sending additional copies to Roy Lindahl, of this material for your files and for your use in communicating with members of the profession in North Carolina about the advisability of stock purchase in the company by the North Carolina Dental Society.

As background for any discussions you might have regarding the importance of DSPIC in the continuing efforts of the Delta system to put together a cohesive national response to the market for prepaid dental care benefits, I would cite the following facts:

At present there are 34 active dental service corporations underwriting and/or administering private or publicly funded programs in the United States. In addition there are approximately ten states that have enabling legislation or an inactive incorporated Plan in existence. As you can note from these figures, the Delta system would be hard-pressed if a truly 50 state national program emerged within the near future. To overcome this problem, concerned service Plans and constituent dental societies began development of a stock insurance company that would be able, upon admittance to the various states, to serve as an underwriting vehicle in national or multistate programs on those occasions when a service Plan in a state was not sufficiently funded to underwrite a program, or as is the case in many states, was not permitted by state stature to undertake the underwriting of programs in its state.

After a campaign of some 18 months duration devoted to the raising of capital through the purchase of shares in the company, the Dental Service Plans Insurance Company became incorporated in 1970 with an initial capitalization of \$600,000.

The first meeting of the shareholders of DSPIC was held in November 1970 in Las Vegas, immediately prior to the opening of the annual session

of the American Dental Association. At that meeting the shareholders—representing 15 Plans, 12 constituent societies and the American Dental Association—ratified the prior organizational actions of the incorporators and elected the first Board of Directors of the company.

Immediately following the shareholders meeting, the DSPIC Board of Directors met and elected the following men to serve as officers until the first annual shareholders meeting: president, Dr. Clarence D. Honig, Southern California; vice president, Dr. John Y. Kim, Hawaii; secretary, Dr. Marvin H. Sims, Michigan; and Mr. Benson L. Allard, San Francisco, treasurer. The Board also approved a motion that the size of the Board be increased from 11 to 12 members and that a special meeting of shareholders be called for the purpose of electing an additional director to fill that space with the understanding that the Board would nominate Dr. Harold E. Eberhardt, treasurer of the American Dental Association for election. In addition, the Board created the management study committee charged with responsibility of developing recommendation on business acceptance priority and administrative matters. Finally, the Board approved the sale of an additional 10,000 shares of stock in the company. The special shareholders meeting was held in December 1970 and Dr. Eberhardt was elected to the Board.

These events climaxed the 18 month campaign to capitalize and activate the company, the formation of which had been strongly endorsed by the ADA House of Delegates in 1968. The total initial capitalization of \$600,000—the minimum permitted under applicable Illinois statutes—was achieved finally by the purchase of stock by the American Dental Association, in an amount totaling \$38,465. Since then, in fulfillment of a commitment made by DDPA, all but one qualifying share of that stock valued at \$60 has been purchased from the Association by DDPA member Plans. In addition extensive efforts have been undertaken, and are in progress, for the admittance of the company to do business in all states wherein its resources will be needed to support the Delta system. Unfortunately, some of these states impose financial requirements that exceed the present capitalization of the company. This is one of the factors that stimulated the company's Board of Directors to authorize the sale of an additional 10,000 shares of stock. Another major contributing factor was the concern of the DSPIC Board that the company would be limited severely in its ability to assist small Plans and those without statutory underwriting authority in their efforts to acquire intrastate business. The successful sale of the additional 10,000 shares will double the company's capitalization and, by extension, will double its capacity to accept underwriting exposure.

The rule often most commonly employed by state insurance departments in measuring an insurance company's stability, is that retained exposure should not exceed five times capitalization. Accordingly, the sale of the new shares will increase from three million to six million the company's ability to serve the needs of the Plans in both multistate and intrastate arenas.

The recent enactment within the State of Illinois of a statute requiring all

non-Illinois based companies to have a minimum capitalization of 1.2 million dollars has further intensified need for additional capitalization by DSPIC. It is expected that as a retaliatory gesture, most state insurance commissions will require all Illinois based insurance companies, such as DSPIC is, to have similar capitalization to be admitted to do business in their states.

At its first annual membership meeting held in Chicago last June, the Dental Service Plans Insurance Company re-elected the same slate of officers, and elected Dr. Charles A. Parkin, president, Delta Dental Plan of Utah to replace Mr. Herbert C. Lassiter, as a member of the Board of Directors. In recent months Dr. C. Gordon Watson, executive director, American Dental Association, was elected to the Board of Directors to replace Dr. Eberhardt as the ADA representative.

In response to the continuing need for increased capitalization of DSPIC in order to enable it to fulfill its assignment by the profession of providing underwriting support for the activities of the Delta system in the national market, the ADA House of Delegates, at the 112th annual session in Atlantic City, requested the ADA Board of Trustees to consider at its March, 1972 meeting "investing an amount, from available surplus funds of the Association, in the capital stock of the Dental Service Plans Insurance Company."

Intensive efforts are underway to achieve a higher level of capitalization of DSPIC through the sale of stock in the company through the investment by service Plans and constituent dental societies that have not previously purchased stock.

As an investment in both the operations of the Delta Dental Plan of North Carolina and the future of the entire Delta Dental Plan system, both the society and service Plan in North Carolina are urged to invest in the Dental Service Plans Insurance Company through the purchase of stock to the largest amount feasible.

I hope the above information will be of assistance to you; if we can be of further service in this matter, please let us know.

—JAMES BONK, Director

# Rational Dental Therapeutics I. Post-Operative Pain

By Louis P. Gangarosa,  
Ph.D., D.D.S.\*

THIS article discusses some of the practical problems associated with post-operative analgesia. In order to illustrate the solution to some of the problems encountered with post-operative pain, data will be presented from a scientific article by Chilton and Lewandowski.<sup>1</sup>

Your patient has had a dental procedure with mild to severe trauma to the tissues, as may occur during endodontic, periodontic or oral surgery, etc. You have reason to suspect the patient might have post-operative pain. You can lighten the patient's anxiety by being certain that an analgesic drug is available to diminish any pain experience.

Problem No. 1. Which patients should receive post-operative analgesics?

As dental practitioners, we are responsible for patient care around the clock. Dr. Monheim<sup>2</sup> states "If the dentist decides that there is even

the remotest possibility of any post-operative pain, the patient should receive a prescription of direct medication, if it is indicated, to alleviate the unpleasantness adequately." This statement is backed up by Dr. Chilton's study. Immediately after single or multiple extraction, he medicated 658 patients with a mild (antipyretic-type) analgesic. The patients recorded pain - severity every hour and were allowed to take another analgesic after four or more hours. Table 1 summarizes the approximate number of patients having pain at hourly intervals after the extractions.

It can be seen that some patients experience pain shortly after the procedure. After five hours, 50 per cent of patients experience pain. Of the patients reporting pain, 10/83 reported severe pain after 1 hour while after 6 hours 61/326 reported severe pain.

From this data, we can predict,

TABLE 1

	Percent Patients With Pain	Patients Reporting Severe Pain	Total Patients Reporting Pain
1 hour	13	10	83
2 hours	23	12	142
3 hours	34	19	183
4 hours	42	39	271
5 hours	50	52	315
6 hours	52	61	326

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in agreement with Dr. Monheim,<sup>2</sup> that a high percentage of patients require a systemic analgesic after extractions. Even when medications were given immediately after extraction, some patients reported severe pain after one hour and a good percentage of patients (about 10 per cent) after six hours.

Problem No. 2. Should I tell the patient to take two of his favorite headache remedy if he has pain or give him a prescription?

Whenever possible, the patient should not be asked to control his own medication. Sound dental therapeutics implies that the dentist will control the medications through prescription and in-office medication. Otherwise, you will never be able to predict whether the patient will take his medication, which medications are in his system and which drug interactions are possible.

Dr. Monheim<sup>2</sup> believes that every post-surgical patient should receive a prescription for enough analgesic for the first 24-48 hour period. The medication prescribed should be tailored to the severity of the procedure (see next section). The author of this article is in agreement with Dr. Monheim, since a pre-

scription is the most professional method of handling the situation and has the greatest psychological impact on the patient.

Problem No. 3. Which medication should be prescribed?

For therapeutic purposes, pain may be classified as follows:

mild

moderate

moderate to severe

severe

Mild pain should be treated with an antipyretic-analgesic such as a salicylate or acetaminophen. Both of these drugs have been found to be equal in potency and usefulness.

Moderate pain is best treated by taking advantage of the synergistic effect of an antipyretic-analgesic and a low dosage (30 mg or ½ gr.) of codeine. A similar principle applies to moderate to severe pain except that a larger dosage (60 mg or 1 gr.) of codeine is required. For severe pain the cautious use of a more potent narcotic drug (such as meperidine) should be considered.

#### REFERENCES

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2. Monheim, L., *Local Anesthesia and Pain Control in Dental Practice*, C. V. Mosby, 1969.
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# A Candid View of Dental Education

*The author is an honor graduate of the UNC School of Dentistry class of 1971. The paper is an address relating his views on his experiences at UNC and is evaluation of the same. It is recommended as enlightening to those of us who have been out of school for a while.*

**By Richard J. Vanek**

THERE'S a rapidly spreading rumor within our class that we're nearing a milestone in a long and comprehensive program of dental education. We purchased it at the expense of our body fluids; our wives might add, at the expense of our sanity. But whatever the price, it now belongs to us. Did we get what we paid for? Well, what was it that we wanted from our education.

As entering freshmen, whether due to limited professional knowledge, or naivety our objectives were simply to start and finish whatever was required of us. The present freshman class, being more advanced than we were as freshman, have a more exacting set of goals. They want to finish a procedure with juniors assisting them. My oversimplified statements point to the obvious; unless one is extremely gifted, he must experience the "system" or he will be restricted in assessing it. That is, one must go through the "system" to not only acknowledge the objectives and inadequacies, but more importantly, to understand them.

As senior post-game players we are better able to redefine several major educational objectives.

1. We desired self-esteem and respect.

2. Second, proficiency, skill and knowledge in our professional endeavors, with open communication between faculty and student.

3. Third, social awareness and relevance to social order, and

4. Fourth, responsibility.

As a recent consumer of dental education here at UNC, I would like to elaborate on whether or not these educational needs were met in the last four years.

Self-esteem and respect of the dental student has been well fostered at the UNC School of Dentistry. In the infant stages of our educational program, and to a certain extent in immediate past endeavors, one might be hard pressed to make that statement. Since on more than just a few occasions students were virtually harassed for lack of didactic knowledge, nearly intimidated for minimal technical finesse and almost abused in their naivety. Not that it wasn't deserved in a few cases — there are always a few crooked teeth in every group. Yet it actually accomplished very little other than antagonizing self esteem and respect. On reflection these incidences tend to be more and more isolated; this is not to minimize the ineffectiveness and irresponsibility of these actions. But the student survived, he learned to adapt, he rolled with the punches,

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Presented at the Annual Awards Banquet, Upsilon Upsilon Chapter, Omicron Kappa Upsilon, Chapel Hill, N. C., May 15, 1971. Dr. Vanek is a 1971 graduate of the U. N. C. School of Dentistry.

but unfortunately he developed a lingering gun-shyness.

Then how do I justify a positive reinforcement of self-esteem and respect.

1. The vast majority of our faculty and administrators exhibit a perceptiveness that is not necessarily unique to UNC, although I'm certainly glad it is here. But possibly it has come about due to the faculty's self-evaluation propagated with the new curriculum. They realize that the system revolves around those clinicians in the white smocks, not the blue ones. They have a high degree of devotion to this type of educational system and to the student. Make no mistake, we do sense this.

2. The faculty also understands that their attitude is our attitude and the majority of them tend to minimize their negative actions, lending a more positive attitude to us.

3. Third, a unique group of instructors actually leave the student, especially in his senior year, with a feeling of professional equality even though it may at times have a rather shaky basis. It takes time and understanding by both parties concerned to place the right word or thought in the right place and at the right time. And the student is grateful that this type of rapport exists here at UNC.

4. Fourth, we tend to identify easily with the faculty, since we are a reflection of them. We are in fact what they are, and we hold the greater majority of them in high esteem.

5. Finally, from a demanding schedule, the faculty finds time to engage us in extra curricular activities. They should realize though that it doesn't help the student's ego if he

perpetually loses the Tricky Dick Golf Tournament. His humility? Yes!

There is little doubt that during our course of training, the students have acquired a high degree of professional knowledge and proficiency, considering their level of experience. This can be attributed to the excellent physical facility. But certainly more important are the administration, faculty and the student himself.

It's apparent that there are several courses that leave much to be desired. At the beginning of each school year, these wayward courses are not quite obvious, but through the rapidly expanding media of student feedback, faculty and administrators more quickly become aware of course insufficiencies. And, son of a gun, they're listening to us, even though we are not always right or practical. What's more to their credit is that our class didn't have to threaten reprisals, pound our fists on conference tables nor burn our grade cards. Instead, there seems to be mutual understanding and cooperation underlying course revision, and if necessary elimination, to allow greater experience and efficiency in our educational system. It's my impression that the faculty and administration work as hard for improvements as do the students. Somehow I even get the feeling that the administrators want to be one step ahead of us or do us one better. But they are more restricted by professional edicts and dental politics than the pseudo-idealistic student. Thus the changes are generally incorporated slower than the student imagines they should. But they do come. In my four years here I have

witnessed several desirable teaching innovations which I hope are an indication of future trends. To mention a few:

1. The use of slide tape presentations have been increasingly incorporated in our education, lending greater efficiency to our learning process, since instructors must prepare and rehearse their material before taping it. Of course it's not in color, but maybe it's best to take just one step at a time. Hopefully, in the future this may free the instructors so that they may have time to confront students on a more personal seminar basis.

2. Another teaching method I am delighted to see being employed more and more is the post-clinical seminar. I can't think of a better way to maximize reinforcement and transfer than to discuss what has just been accomplished. Some of the overlooked problems and finer points of a procedure are easily aired in this type of situation.

3. A third and invaluable aid to learning that has been emphasized by the faculty is that a student may seek opinions and help on a personal basis, with relatively open communication and compassion from the faculty.

If these few examples that we have witnessed are in fact trends for the future, possibly we will see:

1. Independent learning centers as in Maryland which allow students to progress at their own rate with taped instruction.

2. Secondly, we may see more flexibility in our course selection. This would enable those that desire specialty training to be freed from intense training in other areas where they are less motivated. This might

result in shorter periods for the specialty training, a greater knowledge of what might be demanded of the student if he pursues this training and considerably lower costs to the public. This flexibility need not only be restricted to those considering specialization but those students entering private practice could compile more training in the areas that interest them most or that they need the most work in. Internships would be of benefit in this area as an integral part of the curriculum.

3. We may also see a re-evaluation of the grading system to give more flexible and generalized evaluation in clinical courses.

4. Possibly we may also see courses for the student set up on a continuing education basis, which will provide an opportunity for the student to learn how to keep up with his dental education once he leaves the school. As I understand it, many of these thoughts and others are now in their incipient stages in the new curriculum, and I am confident that when they mature they will be quite fruitful.

As students we realize that it is extremely difficult to properly educate us. On the one hand, we are introduced to such a wide spectrum of material, that even under excellent conditions we couldn't possibly absorb and retain it entirely. But on the other hand, if we could retain all the material presented in this four year curriculum, it would only be a fraction of what we would need to know during our pending dental career. Our present curriculum has done a relatively adequate job in balancing these two extremes. But as mentioned, I anticipate a better system under the new curriculum,

judging the experimental bits and pieces which we have sampled so far. One additional key point hopefully incorporated should be an earlier and more comprehensive awareness of professional aims. This might lend a forceful punch to each student's drive, which is the most important factor in their learning process. Our class has desire but somehow it has been channeled from education to graduation. Not that both cannot be accomplished simultaneously, but somehow more energies are funnelled into the tensions of requirement completion than are warranted. Thus the student has recently been placed in the unique position of demonstrating proficiency and knowledge for the sake of graduation, rather than learning. I question the advisability, not the efficiency, of this type of motivation. Yet I hesitate to overly condemn this system since:

1. On a practical basis it does provide a positive incentive for clinical experience.

2. It affords the student the means to develop professional proficiency and skill, while introducing him to the pressures of our profession.

3. It's my impression that even under such a requirement system the administration is not so naive that they do not subjectively review the student as an individual, requirements completed or not.

And finally, it's difficult, not that it's impossible, to conceive of a more efficient system even with its inherent inadequacies.

But besides the less than ideal manner for motivation, our requirement system also has the effect of forcing the student to minimize his didactic experience. The student be-

comes aware that for the most part the clinical requirements, not the lecture material, will determine his chances for graduation. If some way were possible to *assure* the student of being judged subjectively as an individual, not by the number of his clinical experiences, he could feel confident that he was not presented with two conflicting areas — one of practical work and one didactic.

These areas of our curriculum should be synonymous. One is needed to accomplish the other properly but ever since we took the Dental Aptitude Exams with its two parts — the academic and the technical, the student has felt like he was attending two schools at once, and expected to graduate from both — especially the practical one.

Social awareness is admittedly a vague and intangible item desired by the dental student. In a restricted sense one might define it as an acknowledgement of personal and professional obligations to society. Through our four years of professional training we have witnessed this social aspect of education in an ever increasing quantity. This is a natural consequence of the recent increased demands of society on the dentist, combined with the tremendous upsurge on his sensitivity to the present era of social justice.

The dental student became aware of these social problems as he entered dental school if not before. They were nurtured from a single didactic course as a freshman, to several areas of instruction as seniors. Even as juniors it included clinical work within and outside the dental school paper, such as Headstart, New Careers, Murdoch, Hospital Dentistry and SHACK. Thus,

not only a sufficient quantity, but I feel also a good quality of reinforcement for social awareness has been afforded the student. This has been perpetuated in such an efficient manner that ideally, even the most unconcerned student realizes some degree of social concern.

But with the student's enhanced and occasionally idealistic social involvement, a contradiction is possibly manifested. Is it feasible to assume that on a practical basis a student can truly become involved with social ills, especially at a time when he is concerned with confronting his own problems, tensions and inadequacies fostered in the highly competitive educational situation? I personally feel that under the present curriculum the student has an opportunity to balance his concern for his problems with that of the patient and the community. Yet, all too often he feels compelled to use the patient and community for personal gain, instead of a desire to help on a health care basis. Fortunately, when this occurs, and I suppose I am talking for the most part about checking off clinical requirements, there is often a sense of regret and even guilt on the student's part. And where there is this guilt, at least there is some form of social concern.

The fourth area I wanted to touch on is responsibility. Our education has, without a doubt, fostered professional responsibility. We acquired this by appointing and organizing patients, critically checking our work, and our necessity for promptness. There are, of course, many other areas I could go into. A result of assuming these many responsibilities has been allowing us to use

school facilities in the evenings, the honor system and personal patient responsibility. But the burden of having this responsibility, that is, all the time required in being a responsible student, has shown its toll. In most instances the majority of the dental students are newly married by the time they graduate. It's hopeful that in the future curriculum the administration realizes the inadequacies in this area and provides the time needed to develop family and personal responsibilities. Not to belabor this point but it's ironic that one's first responsibility should be to his family and himself, yet as students quite frequently this is a most deficient area. It's an unfortunate situation when a student is in the clinics during the day and then feels compelled to spend his evenings continuing educational endeavors. And then on the weekends he spends most of his time trying to recover from the past week or working that part-time job for a few extra dollars.

The student pushes himself long after his time to stop. No wonder he's tuckered out and thinks he's finished his dental education when in fact he's just begun. Also it takes a rare breed of woman to stay married to a husband who prevails in spirit, not mind or body. Somehow I'm sure that the wife's "Putting Hubby Through Award" seems very inadequate. If a student misses a lecture, or doesn't show up for a clinic period, you should have some compassion. He's not always out on the "links," sometimes he's home cementing family relations.

When I was approached to speak this evening, I was informed that I could choose my own topic. I thought of elaborating on secondary

palatal closure in the A/Jax mouse, but several of you have already heard that one. Then I thought about the sex hormone of the female cockroach, but realized that that might be too specific for the ladies. So I considered airing my great passion and "complain." My point is that when I really began to reflect on my education these past four years, much to my amazement, I found very little to complain about. In fact, with few exceptions our class has received a darn fine dental education. There are inadequacies but they are now in the process of being examined and hopefully solved. Thus in presenting this candid view of our education it simultaneously appears to be a balanced view. The system is not omnipotent, and I doubt that it ever can be. It is limited to an attempt to help fulfill as many of the student's goals as are feasible, not all of them. Many of the deficiencies are being remedied with the combined

help of the student, faculty, and administration. But it's hard to satisfy the needs of 275 individual students, even though they do share a common goal. For those needs that can't be adequately met, the student, on an individual basis, will have to take up the slack with a balancing of his energies, attitudes, and desires.

Well, did we get what we paid for? Let me answer it this way. And please understand that I am not attempting to discourage the progressive trends blooming here at UNC. Quite the contrary, they can only enhance the system and help the student. But it's my firm belief that even with the heretofore mentioned inadequacies, inherent to the system or not, and with any type of curriculum set up in the future attempting to compensate for these inadequacies or not, the student receives from his education precisely what he puts into it, which in most cases is a great deal.

# North Carolina Dentists Comment on Expanded Duties

*In conjunction with the UNC project to study effects of expanded duties of auxiliaries, the author sent out a questionnaire last December for private practitioners' comments on expanded duty utilization. This article includes samples of some of the answers.*

by  
**Roy L. Lindahl, D.D.S., M.S.\***  
and **Mrs. Sandy Huff, B.S.†**

Last December many of you received a questionnaire in the mail. The results of this questionnaire are being tabulated now, and will appear in later publications. However, an analysis of the comments reveal that North Carolina dentists who returned the questionnaire have a firm view of what auxiliaries should be allowed to do. A sample of the 183 comments is below. Although the vast majority of the comments were favorable to some form of expanded duties, we have tried to include a cross-section of all types of opinions. NOTE: the term "EDA" was used to stand for "Expanded Duties Auxiliary."

The question was: "What aspects of the expanded duties issue do you think are most important? How would it affect you and your practice?" These are a few of the answers. . . .

*The "EDA idea" is probably the only salvation dentistry has in its efforts to provide dental services in the future. This is especially true in the rural areas similar to where I practice. We need help and we need it quick and we are not going to get it in the form of more dentists moving into rural areas. The most obvious solution is to allow some of the basic, repetitive procedures be performed by less educated but qualified auxiliaries. Dentistry has labored too long under several illusions:*

*(1) that placing matrices, restorations, etc., are "so technical" that only licensed dentists should perform these functions.*

*(2) that our great "technical and dexterity" image would be spoiled by delegating auxiliaries some new functions.*

*(3) that patients may balk at the EDA idea. (Nonsense, most patients now feel fortunate just to be seen by a dentist!)*

*(4) that preventive dentistry is for the "public health boys." (Actually, this is the area where we should be devoting a full 70-80 per cent of our time. As it is we spend at best only 10-12 per cent of our time in this direction.)*

*(5) that lay people or our "hired help" are not capable of performing the EDA functions unless subjected to long formal educational programs.*

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*(Another nonsensical idea! I am continually amazed by progress of my auxiliaries to my "on the job" training programs and these people have at most only a high school education).*

*My idea of how to best train EDA would involve a minimum of formal educational courses and a heavy emphasis of on the job training with frequent one day or weekend "special procedure" courses at nearby technical schools.*

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I feel that formal training for the EDA is an absolute necessity. To leave the training of this type of assistant to the dentist is the equivalent of leaving the training of dentists to other dentists (an apprenticeship arrangement). My patients would accept an EDA more readily if they knew she had a good solid background for this rather than on the job training. Living in a location where manpower shortage is critical, doing quadrant dentistry on 20 patients a day, 5 days a week and still seeing an appointment book overcrowded makes me realize that the most important effect an EDA would have on my practice is allow me to work more efficiently and help to alleviate some of these problems.

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*Formally trained EDAs are a nice ideal but they are not a practical solution to the manpower problem facing us this year or the next 10 years. Therefore, I feel the dental assistant manpower problem can best be solved (and the public best served) by on the job training plus intensive short courses for subjects such as x-ray, etc. Expanded duties for on the job trainees may not be thrown wide open. I'm sure there should be some restrictions but at the same time I do feel these people are capable of being adequately trained for many tasks while on the job. A very large portion of today's dental assistants are either married, widowed, or separated, or just unable to continue their education beyond high school. There are many very outstanding workers in this group and because of family responsibilities they could not or would not go to school for extended formal training. To eliminate this group as a potential source of employees would greatly compound (our) manpower problems rather than to ease them. For (extensive) training for expanded duties would eliminate this source of employees. The answer seems to be expand duties within reason but permit most training to take place on the job.*

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This will be a real breakthrough for the GPs. I really feel the only way this program can be successful is that the dentist utilizing the EDA be very strict about her or his work. The men doing "poor" dentistry now are the problems that will have to be worked out. Who knows, it may even raise their quality of dentistry some. As far as injections, I have never known why a girl could not infiltrate on the maxillary as well as I can. With the proper "Schooling" or instruction, they could and should be allowed to give mandibular blocks. This is personally speaking, but I feel my chairside assistant could place bands, wedges and carve better amalgams than  $\frac{1}{4}$ - $\frac{1}{2}$  of the practicing dentists in this state, judging from

some of the work that comes into my office from "local men." I do not have an adequate answer as to their proper training. I feel I could teach my girl to be a damn good EDA, but on the other hand I know many dentists who do not know or do not do good dentistry themselves, that should NOT be allowed to self train EDAs. So I guess UNC should work out the details of just how much training and how long is necessary. Please feel free to consult me and if necessary I would enjoy the opportunity for using my office in a "pilot" project.

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*Generally, I would say that we, as orthodontists, utilize personnel rather well. Unfortunately, many duties which are done by assistants in the specialties approaches breaking the current law. Whether this is due to excessive permissiveness on the part of the practitioner, or an archaic law, is debatable.*

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I am fed up seeing lousy dentistry performed by DDS's and DMD's—men who don't place matrices properly now because they can't plug amalgam fast enough. I believe in quality dentistry, not quantity. The EDA program as I see it would promote assembly line dentistry. The man who can't place a matrix properly is in no position to relegate such duties to an auxiliary. When a patient walks out of my office with a restoration in his mouth, he knows that I did it and that I had to be satisfied with it before I released my patient. A man who cuts preps part time and acts as a foreman most of the time is too busy to demand the quality I demand of myself. My patients come to me for my work, not for my auxiliary's. I hear too often complaints about how other doctors spend too little time with their patients. I feel such complaints will increase with this program. Patients are paying good fees for dental services performed by their dentist. I feel they are entitled to these services.

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*The most important issue is to provide quality dental services for more people. It seems to me that the Board has completely lost sight of this. They are tangled up with methods—Dentists should be graduated that can and will take the responsibility for supervision of his auxiliaries and will be sure of insuring quality dentistry. I feel that when schools begin graduating technicians, the whole climate will change.*

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I have only been in practice for one year and people are already begging for appointments that we can't give them. We need all the help that we can get. EDA assistants (are) an excellent way to help the problem.

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*The increasing demand for dental attention, in my opinion, makes it mandatory that duties for auxiliaries be expanded into areas where equally good care can be given by auxiliaries but always under the direct supervision and responsibility of the dentist. Rather than lessen quality, of amalgam restorations, for example—I believe in many cases it would be improved. As a practical approach to providing increased care with quality, present and new assistants could be certified in areas of dental care; for*

*example, an assistant with a high school education and one or two years experience as a chairside in a dental office might be eligible to attend a one or two day course on polishing teeth and amalgam and giving topical fluorides and on successfully completing this be awarded a certificate for this area of dental care. Another two day course on x-rays might be available and a certificate given for successfully completing it. The same could be true for placing a matrix and wedging; giving local anesthesia; taking alginate impressions for study models, etc. Written and/or practical examinations in each area could be given, or certification made by the instructor (duly qualified and appointed). The present training programs should be enlarged to train a girl in all these areas and award her certificates in each of the areas in which she qualifies plus being designated a CDA as in today's set up. Through this approach a mother of four, for example, who does not have the time or the money to take a long formal course and who wants to work as a dental assistant could over a period of time prove to be a valuable asset to her community's dental health. These courses could be made available to all areas of the state. Many women who are capable could through a program of this type be made available to the profession. Certificates should be posted in obvious and clear view of the public. A statement to the effect that only assistants certified in these (or this) areas are legally allowed to perform these duties (and any others performing these should be reported to the N. C. State Board of Dental Examiners), should be clearly apparent on each certificate. Regulation presents an apparent problem; however, the same dentist who is trusted today to perform competent services for his patients will be the same one supervising expanded duties tomorrow. Is it better not to polish amalgam restorations due to a crowded schedule or call on a qualified assistant to do it and face the possibility that an unqualified assistant might attempt it? Is it better to overlook needed prophylaxes due to the pressure of more demanding needs or to call on a qualified assistant to polish, floss, and give home care instructions after the dentist has scaled the teeth (this is especially true in the more rural areas where hygienists services are hard to obtain)? Are we to deny needed attention because there might be an infraction of the regulations? The individual dentist can train a girl well in many areas, needs help in training in many others, and if duties are to be expanded should be required to have it in others.*

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I feel dental assistants should be allowed to perform all duties except cutting hard and soft tissue, extracting teeth and giving anesthetics—under the supervision of the doctor. The doctor assumes all responsibility for all procedures in his office, and must be present during patient's treatment. If this policy were adopted it would be necessary to spot check the work by a dental examiner. I feel this method would actually improve the quality of dental work done today. (For example) The dentist too lazy to put on a rubber dam would now have the dam placed. In making diagnosis the dentist too lazy to make study models and pictures would have it done for him.

*If any more supervision is needed in my office I will have to reduce my load by ½. I agree that the proper use of auxiliary personnel is advisable but I fear that dentistry is about to overshoot the target.*

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Personally, I think anyone working in a patient's mouth needs formal training of at least two years, and then only under the supervision of a licensed dentist. It's hard enough for a dentist to do good work for the educated public—these people must be restored to good dental health without pain and at their convenience. How can an untrained person do anything except hurt a practice? On the job training is impossible as far as I am concerned except possibly for chairside assistants. Let's keep dentistry in North Carolina on a high professional level.

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*The issue is extremely important and should project beyond the statistic stage. The DDS in an effort to upgrade the image of dentistry has shackled the profession with unrealistic approaches. On one hand we try to appease the demand for the production of more skilled health personnel and agree that the public is entitled to adequate, accessible care. On the other, we allow our policy making groups to restrict a resource that could make responsible, accessible health care more so. Too long we have been concerned with (offending) the too well entrenched female help allied to our profession by allowing expanded duties for aux. help. More than the Prima Donna in the hygiene field we need dedicated willing young women to take on expanded duties. They will welcome office supervision and we dentists would welcome the opportunity to put our time to more productive and skilled work. Who benefits by this? The patients on the long waiting lists, the patients that are (deferred) for treatment, and who are the patients? The public that grant(ed) us the privilege of practice in the first place.*

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I think the EDA is a splendid idea and I am all for it. If used properly it should help us see more patients and render a better service, too. However, I have the ugly thought that this very thing could lead to poorer dental service to more people. It has certainly happened in other countries. Would this be better than no dental service at all to so many people? I don't know! I feel that I am guilty already of trying to render a service to too many patients and consequently not doing the thorough job that I should. Would I use the EDA to lessen my load, to concentrate on the real need or would I use this extra help to mass produce more dentistry?

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*The auxiliaries must do more and more of the work under the supervision of the dentist. Just as it would be foolish for a businessman to do a lot of typing, etc., I think it is poor business for a dentist to do the many things in his office that can be done equally well by qualified assistants, hygienists, technicians, etc.*

I use several auxiliary personnel but this issue of expanded duties worries me. Ask any dentist who really tries for good work what percent of the dentistry do you see in patient's mouth that is of acceptable quality, and not many will answer 50 per cent. At a time when we need stricter controls the efforts seem to be in the opposite direction. Many men wish to return to the apprentice situation. Make any change one that will improve the quality and fee for our patients, and not changes to increase production and income at the public's expense.

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*We should strive to achieve what Australia has with its dental nurse. I also think we should consider including male employees as EDAs and hygienists.*

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Profession could put to use the experience and training of Dental Technicians leaving the military. While under my command, several of these men learned to competently give injections, suture, place matrixes and carve restorations, take impressions, place temporary fillings after excavating gross decay, and even perform routine extractions. I would welcome these men into my practice—at a very good salary—whenever the regulations allow for it. In questionnaire, I believe you referred mainly to female EDAs who would require advanced training, but don't forget the large supply of trained military Dental Techs.

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*I would like to make one observation which the economic advisors seem to overlook. Dentist(s) are working on real live people with personalities, fears and anxieties which differ with each individual. This must be evaluated by the dentist, and the only way to do this is association with the patient. People are not inanimate objects which can be herded together and treated in mass production. Divorcing the dentist from the patient by the use of auxiliary personnel may increase production but would the increase in production be worth the faith some people will lose in the dentist and the profession as a whole.*

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I have indicated that the EDA do all the patient education. The reason for this is simply that the salary we pay a hygienist is so high that in order to profit from their services we must flood them with patients. They cannot be given time to properly instruct the patient in all these other areas because their "bread and butter" is cleaning teeth!! If you do give the hygienist time to educate the patient, you must charge the patient \$40-\$50 an hour and most patients feel this is an awful price to pay to "have their teeth cleaned." Also, such a long appointment period greatly reduces the number of recall patients a hygienist can handle—I would need two hygienists. If the assistants were allowed to *polish* and apply fluoride, leave the *scaling* to the hygienist, and then let patient education become a very big area of your practice, managed by the hygienist along with a special assistant who would teach oral hygiene and prevention. **BRING ON THE EDAs!!!**

## Oral Irrigation and Bacteremia

USE of high-pressure pump-type irrigation units by persons who have periodontal (gum) disease can cause bacteremia (the presence of bacteria in the blood), according to two studies by dentists at the College of Dentistry of Ohio State University.

The significance of these findings is important because of the relationship between bacteremia and bacterial endocarditis the inflammation of the lining of the heart membrane and its connective tissue bed according to the reports published in the December, 1971 issue of the *Journal of Periodontology*. Many of the microorganisms implicated in bacterial endocarditis are common inhabitants of the gingival tissue. Transient bacteremia occurred following oral irrigation in 2 in 30 in persons with gingivitis (mild periodontal disease) and in 15 in 30 in persons with periodontitis (moderate to severe periodontal disease).

Alan Robert Romans, DDS, MS, and George R. App, DDS, MS, studied 30 persons who had generalized, chronic, mild papillary gingivitis. None had previously used an oral irrigator, and none had known diseases communicable through the vascular system.

Blood specimens were taken from each person prior to the study, then each person was instructed individually in the correct use of the oral irrigator. Pressure dials on the units, calibrated from 1 to 10, were set on 5. Each was told to direct the

stream of water into the gingival crevice, holding the tip of the unit  $\frac{1}{8}$ - to  $\frac{1}{4}$ -inch away from the gums. The unit was used for one minute, irrigating all tooth and gum crevices.

Another blood specimen was taken one minute after conclusion of each test. Microorganisms were found in the post-irrigation specimens of 2 of the 30 subjects in the gingivitis group. None of the control blood samples taken before use of the irrigators yielded any microorganisms when cultured.

James E. Felix, DDS, MS, Samuel Rosen, BA, MS, PhD, and Dr. App (who participated in both studies) tested the other group of 30 persons, all of whom had generalized periodontitis of at least 10 teeth. Blood samples were taken before and after use of the irrigators. The irrigators were used the same as in the tests of the gingivitis group.

The post-irrigation blood samples from the Felix-Rosen-App study showed microorganism in the cultures of 15 of the 30 patients.

Because of the relationship between transient bacteremia and bacterial endocarditis, there is a need to reevaluate the use of oral irrigation units by patients with periodontal disease who also have a history of cardiovascular defects, the investigators concluded.

Previous studies showed that 50 per cent of all cases of bacterial endocarditis could be traced to gingival manipulation leading to gum hemorrhaging. Patients who

have had rheumatic heart disease, arteriosclerotic heart disease, septal defects, injured heart valves, prosthetic valves and a history of cardiovascular surgery are particularly subject to endocarditis developing from periodontitis.

The clinicians said further investigation is needed in a number of related areas. These include:

(1) Evaluation of the incidence of transient bacteremia to total patient evaluation.

(2) Clarification of the occurrence and significance of systemic bacteremia following all oral physiotherapy procedures.

(3) Investigation of the use of oral irrigation units utilizing higher

water pressures than those used in current studies, with persons who have healthy gums.

Drs. Romans and Felix were graduate students in the Department of Periodontology at the College of Dentistry at the time of the investigations. Dr. App is Professor Chairman and Graduate Director of the same department. Dr. Rosen is a Professor, College of Dentistry, and Professor, Academic Faculty of Microbial and Cellular Biology, Ohio State University.

THE AMERICAN ACADEMY  
OF PERIODONTOLOGY  
211 EAST CHICAGO AVE.  
CHICAGO, ILL. 60611

# **Official Position of American Society of Oral Surgeons on National Health Care\***

It is not uncommon for physicians within the specific limits of their state licenses to manage problems within the oral cavity and its supporting structures. This overlap of dental practice has been long known and poses special problems with the emergence of legislation authorizing compensation for the services of a specific provider rather than for a specific service. This first occurred in certain facets of Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act. With the enactment of this legislation, discrimination against specific providers of health services was officially sanctioned.

Today, we are faced with several new proposals for health legislation, most of which provide for unlimited services of a physician. As is true with Medicare and Medicaid, these national health programs would deny recognition of covered oral health care when provided by a dentist, yet recognize the same services and care if performed by a physician. At a time when the lack of health manpower in this country is a major consideration in the implementation of any national health program, it is inappropriate to deprive the public of available services by use of discriminatory measures which, in effect, decrease the number of qualified providers.

It is acknowledged that the extent of services covered under any national health program is a decision to be made by the Congress and the public. Once a procedure or treatment is designated as covered under any program, however, it must be recognized that the only valid criterion for determining reimbursement to the consumer or provider is whether the professional service and care is provided by a person legally entitled to render such service. Under no circumstances should the degree or discipline of a duly licensed provider be a factor in determining his eligibility.

Therefore, it is strongly contended, that ANY LEGISLATION THAT INCLUDES HEALTH CARE OF A NATURE THAT A DENTIST IS LICENSED TO RENDER SHOULD INCLUDE THE SERVICES OF DENTISTS AS CONTRACTUAL PROVIDERS.

The providing of relief and control of pain, surgical care of trauma to

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\* Adopted by ASOS House of Delegates, October, 1971.

the oral and contiguous structures, and rehabilitative surgery for defects and diseases of the oral and maxillofacial area are within the professional purview and competence of the dental practitioner. Moreover, the diagnosis and non-surgical management of oral diseases also are professionally recognized services provided by members of the dental profession.

The American Society of Oral Surgeons considers it a responsibility to the citizenry of the United States, their dental colleagues and its members to express concern regarding the possibility of such discrimination and views its position as imperative and in the best interest of the public health of the nation.

Further, the testimony before any governmental agency should be devoted to the "essentiality" of dental care, now a policy of the American Dental Association, *with the highest priority on emergency dental care*, including dental services such as control of bleeding, control of life-hazardous oral and maxillofacial conditions, for example, oral cancer and cellulitis; disfiguring oral and maxillofacial deformities, relief of severe pain, treatment of injuries to the teeth and supporting tissues and elimination of major acute infection. In addition, the American Society of Oral Surgeons supports the position of the American Dental Association for the provision of preventive dental care to the needy children of this nation.

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# Items of Interest

## Champus Guidelines Issued

Officials of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) announced that expectant mothers eligible for CHAMPUS benefits are authorized dental care, if, in the opinion of the attending physician and dentist, the dental care is necessary during the pregnancy to protect the health of the expectant mother and the unborn child. In response to numerous inquiries that have been received by CHAMPUS regarding the scope of dental care which is authorized, CHAMPUS officials have announced the following guidelines.

Dental care required to eliminate foci of infection which might prove detrimental to the health of the expectant mother or unborn child is authorized to include extraction of teeth, endodontics, periodontics, restoration of carious teeth, oral hygiene treatment and those diagnostic procedures necessary to provide the aforementioned care. Gold restorations are authorized but *only* if the doctor is unable to adequately restore the tooth by means of amalgam or another accepted dental material other than gold. CHAMPUS will also authorize the replacement, by means of a prosthetic appliance, of a tooth or teeth extracted during the pregnancy. However, the replacement of teeth that were missing prior to the pregnancy is *not* authorized unless the absence of said teeth will result in marked diminution of the masticatory process, thereby resulting in nutritional deficiencies which could seriously compromise the pregnancy. If a

prosthetic appliance is provided to replace teeth not extracted during the pregnancy, written justification for this care from the physician and dentist must be submitted with the claim. Replacement of teeth, when authorized, must, of course, be accomplished by the most economical means that will adequately restore the dentition.

Statements of charges for authorized dental care must be submitted to CHAMPUS, upon completion of treatment, on DA Form 1863-2 and must be accompanied by a statement from the patient's obstetrician verifying the pregnancy and giving the estimated or actual date of delivery. Preauthorization for dental care is not required. Authorization for dental care terminates with the termination of the pregnancy, with the exception that those teeth extracted during the later stages of pregnancy may be replaced within a reasonable time subsequent to the termination of the pregnancy.

## Minnesota Dentists Favor Expanded Functions Aux.

Most dentists in Minnesota are in favor of turning more of their duties over to a trained assistant, though considerable doubt was expressed about delegating such tasks as filling teeth or drilling out cavities.

A 1971 survey of Minnesota's 2,200 dentists indicated that over 90 percent of the 2,040 dentists who responded felt that an expanded duty auxiliary would permit them to provide more dental services and to concentrate on treat-

ment requiring their specific skill and judgment. But only 17 percent felt that cavity preparation should be among the assistant's new duties.

According to their responses, most dentists felt that patients would be receptive to receiving more dental services from a trained auxiliary. Nearly 70 percent of the respondents felt that the employment of an expanded duty auxiliary might result in greater income for the dentists, and one-third foresaw the possibility of a reduction in patient fees.

In general, the younger dentists in Minnesota, most of whom had exposure in dental school to a program involving an expanded duty auxiliary, were more optimistic than their older counterparts about the various advantages which could result from the utilization of expanded duty assistants.

### **University of Iowa Offers Graduate Program**

The University of Iowa offers a graduate program for dentists who wish to prepare for careers in teaching by combining theory from the behavioral sciences with supervised teaching experience in the College of Dentistry. Research in educational practices is the central theme of the program, and each course of study is tailored to meet individual interests and abilities. Two years of study lead to the MS degree, and the PhD is possible with additional academic pursuit. A limited number of post doctoral fellowships carry stipends of \$7,000 per year plus tuition. Additional information can be obtained by writing Dr. D. E. Killip, College of Dentistry,

The University of Iowa, Iowa City, Iowa 52240.



### **Guilford County Dental Society Celebrates Golden Anniversary**

On October 12, 1971, the Guilford County Dental Society celebrated its 50th year of existence. Special honor was given to its three surviving charter members: Dr. T. E. Sikes, Sr., Dr. C. C. Poin Dexter, and Dr. H. A. Edwards.

Above Dr. T. E. Sikes, Sr. (left) slices the Golden Anniversary Cake with the assistance of Dr. Julian R. Rogers, president of the Guilford County Dental Society.

It was a gala occasion with all members wearing hats with the year they joined the Society lettered on them. Someone who represented each era spoke about dentistry during that period. There were exhibits of equipment, books, and catalogues used 50 years ago. Dr. Neal Sheffield, Sr., showed movies of members of the Society which he made in 1934 and 1935.

(Continued on page 45)

★  
*Preliminary  
Program*  
★



**116th  
Annual Session**  
**North Carolina Dental Society**

**May 14-17, 1972**

**THE CAROLINA  
PINEHURST**



**WADE H. BREELAND**  
President



**JOSEPH M. JOHNSON**  
President-Elect



**BENJAMIN R. BAKER**  
Editor-Publisher



**RALPH D. COFFEY**  
Speaker of the House

# **NORTH DENTAL OFFICERS**



**ROBERT H. GAINERY**  
Vice President



**JAMES A. HARRELL**  
Secretary-Treasurer

**CAROLINA**  
**SOCIETY**  
**1971-1972**



**FAY H. CULBRETH**  
Chairman, Executive Committee



**M. L. CHERRY**  
General Chairman, Annual Session

# Program

## SUNDAY, MAY 14

- 8:00 a.m. Golf Tournament—Pinehurst Country Club  
12:00 Noon American College of Dentists Luncheon—Crystal Room  
1:30 p.m. Registration Desk Opens  
3:00 p.m. Table Clinics—Cardinal Ballroom  
4:00 p.m. Board of Directors, Dental Foundation of N. C., Inc. —  
Azalea Room  
5:30 p.m. Social Hour—Poolside  
Honoring N. C. Dental Auxiliary  
8:30 p.m. First General Session—Cardinal Ballroom  
Presiding: Wade H. Breeland, D.D.S.  
Invocation: R. B. Barden, D.D.S.  
Recognition of guests and allied organizations  
Address: Wade H. Breeland, D.D.S., President, North  
Carolina Dental Society  
Address: Louis A. Saporito, D.D.S., President-Elect,  
American Dental Association  
Report: John M. Faust, D.D.S., Trustee, Fifth District  
Nominations for officers 1972-73

## MONDAY, MAY 15

- 7:30 a.m. District Officers Breakfast—Crystal Room  
9:00 a.m. Commercial Exhibits Open  
9:00 a.m. An Evaluation of Modern Restorative Dental Materials and  
Technics Designed for Clinical Success—Cardinal Ball-  
room  
Ralph W. Phillips, M.S., D.Sc., Indianapolis, Indiana  
Moderators: David H. Freshwater, D.D.S.; J. B. Freed-  
land, D.D.S.  
10:45 a.m. Their Smile—This is Your Life—Cardinal Ballroom  
M. L. Butterworth, Jr., D.D.S., Plantation, Florida  
Moderators: Kenneth M. Ray, D.D.S.; Baxter B. Sapp, Jr.,  
D.D.S.  
12:00 Noon International College of Dentists Luncheon—Crystal Room  
2:00 p.m. Dr. Phillips, continued—Cardinal Ballroom  
Moderators: David H. Freshwater, D.D.S.; J. B. Freed-  
land, D.D.S.  
3:15 p.m. Dr. Butterworth, continued—Cardinal Ballroom  
Moderators: Kenneth M. Ray, D.D.S.; Baxter B. Sapp, Jr.,  
D.D.S.; Pearce Roberts, Jr., D.D.S.  
5:00 p.m. Commercial Exhibits Close  
5:00 p.m. Fraternity Hours  
5:30 p.m. Aloha Carnival Reunion—London Grill  
6:00 p.m. Dental Alumni Association of Medical College of Virginia,  
Social Hour and Dinner—Crystal Room  
8:30 p.m. Second General Session—Cardinal Ballroom  
Presiding: Wade H. Breeland, D.D.S.  
Invocation: Robert H. Watson, D.D.S.

Report: James A. Harrell, D.D.S., President, Dental Foundation of N. C., Inc.

Dental Education and Research on Dental Auxiliaries—James W. Bawden, D.D.S., Dean, UNC School of Dentistry

Post-payment Plan for Dentists—John P. Carr, vice president, Master Charge Division, First Citizens Bank & Trust Company, Raleigh

Election of Officers

Selection of site for 1974 Annual Session

## **TUESDAY, MAY 16**

- 7:30 a.m. Past President's Breakfast—Crystal Room  
Presiding: W. L. Hand, Jr., D.D.S.
- 9:00 a.m. Commercial Exhibits Open
- 9:00 a.m. How to Save More Tax Free Dollars . . . Professional Incorporation—Cardinal Ballroom  
Robert P. McGraw, D.D.S., Independence, Missouri  
Moderators: Mitchell W. Wallace, D.D.S.; Guy R. Willis, D.D.S.
- 10:45 a.m. Dr. McGraw, continued—Cardinal Ballroom  
Moderators: J. O. Thorpe, D.D.S.; Claibourne W. Poin-dexter, D.D.S.
- 2:00 p.m. Dr. McGraw, continued—Cardinal Ballroom  
Moderators: J. O. Thorpe, D.D.S.; James H. Lee., D.D.S.
- 3:45 p.m. Dr. McGraw, continued—Cardinal Ballroom  
Moderators: Mitchell W. Wallace, D.D.S.; Pearce Roberts, Jr., D.D.S.
- 5:00 p.m. Commercial Exhibits Close
- 5:30 p.m. Reception—Azalea Room  
Honoring members and new members
- 7:00 p.m. Annual Banquet—Dining Room  
Toastmaster: Robert B. Litton, D.D.S.  
Invocation: James A. Harrell, D.D.S.  
Presentation of President's Emblem: S. Everett Moser, D.D.S.  
Golf Awards: John H. Dixon, D.D.S.
- 8:30 p.m. Entertainment by the Dismembered Tennesseans—Cardinal Ballroom
- 9:30 p.m. Dance—Cardinal Ballroom  
Featuring the music of Boyce Roberts and the Executives

## **WEDNESDAY, MAY 17**

- 9:30 a.m. Projected Clinics—Cardinal Ballroom
- 11:30 a.m. Third General Session—Cardinal Ballroom  
Presiding: Wade H. Breeland, D.D.S.  
Invocation: Richard P. Belton, D.D.S.  
Installation of Officers  
Drawing for door prizes  
Adjournment, sine die

# Essayist

**RALPH W. PHILLIPS, M.S., D.Sc.**

Assistant Dean for Research  
and  
Research Professor of Dental Materials  
Indiana University School of Dentistry



**Monday, May 15, 9:00 a.m. and 2:00 p.m.**

**Cardinal Ballroom**

## **AN EVALUATION OF MODERN RESTORATIVE DENTAL MATERIALS AND TECHNIQS DESIGNED FOR CLINICAL SUCCESS**

This presentation is concerned with the newer advances in this field and includes biological considerations in the selection and use of dental materials; the clinical significance of marginal leakage and the comparative ability of various restorative materials to resist caries and the merits of fluoride containing cements and restoratives; the current status of adhesive restorative systems, including pit and fissure sealants, will be summarized; recent research with the amalgam restoration including minimal mercury technics and spherical alloys; a critical evaluation of newer silicate and resin formulations; an evaluation of the composite resins including clinical observations on their use in Class IV and Class II restorations; a discussion of the new carboxylate and zinc oxide-eugenol permanent cementing agents. This talk will clarify some of the controversy related to the many new products and claims made for them, as well as emphasizing manipulative factors which affect their success. The clinical application will be continually stressed.

# Essayist

**M. L. BUTTERWORTH, JR., D.D.S.**  
Plantation, Florida



**Monday, May 15, 10:45 a.m. and 3:30 p.m.**

**Cardinal Ballroom**

## **THEIR SMILE—THIS IS YOUR LIFE**

All successful practices are built upon satisfied patients. Esthetics is one of the least understood facets of dentistry.

Drs. Frush and Fisher have applied the S.P.A. factor to dentistry, and have coined the descriptive word "Dentogenics," which means the restoration adds to that person's charm, character, and dignity in a fully expressive smile.

The application of the S.P.A. factors (Sex, Personality, and Age) gives the dentist certain guidelines, which, if followed, will assure the pleasing appearance the patient and the doctor seek.

This session will cover all the factors necessary to create pleasing esthetics which, in turn, controls the psychological happiness and personal acceptance of complete dentistry by the patient. The smile on his lips must be a reflection of the smile in his mind.

# Essayist

**ROBERT P. MCGRAW, D.D.S.**

Independence, Missouri



**Tuesday, May 16, 9:00 a.m. to 12:00 noon  
2:00 p.m. to 5:00 p.m.**

**Cardinal Ballroom**

## **HOW TO SAVE MORE TAX FREE DOLLARS— PROFESSIONAL INCORPORATION**

Professional incorporation and group practice offer a practical and effective vehicle to enable one to practice in an enjoyable manner and yet provide quite adequately for a comfortable retirement—tax free.

This seminar will emphasize the following:

- Income range necessary to make incorporation practical.

- Articles of Incorporation

- Employment contracts

- Partnership agreements for ownership of buildings, equipment, etc.

- Profit sharing and pension trust instruments allowing for 0 to 80 per cent of taxable income to be set aside tax free and tax sheltered.

- Freezing of Keogh plans.

- Corporate liability as compared to partnership liability.

- Personal ownership of equipment and leaseback to corporate entity.

- Recapture of investment credit and depreciation on personal tax return.

- Freedom from the trivia of administration through utilization of trained management. How to merge one or more practices.

- Board of Directors meetings; agenda, record keeping, etc.

- Group purchase economy

- Spread of income and expenses as per department

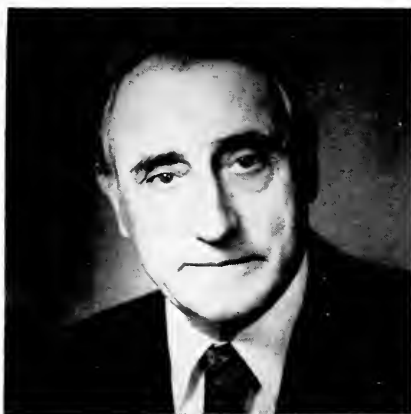
- Fair and equitable liquidation of one's practice in event of death, disability or retirement

- Proper utilization of all ancillaries; scheduling, etc.

- Contractual employees v/s salaried

- Fringe Benefits

## A. D. A. Guest Speakers



**LOUIS A. SAPORITO, D.D.S.**

Newark, New Jersey  
PRESIDENT-ELECT  
AMERICAN DENTAL  
ASSOCIATION



**JOHN M. FAUST, D.D.S.**

Hattiesburg, Mississippi  
FIFTH DISTRICT TRUSTEE  
AMERICAN DENTAL  
ASSOCIATION

**Sunday, May 14**

**8:30 p.m.**

### ASSOCIATION AFFAIRS 1972

Dr. Saporito was elected president-elect of the American Dental Association in October of 1971. Prior to his election as president-elect, Dr. Saporito served six years on the Association's Board of Trustees.

A 1922 graduate of Columbia University School of Dental and Oral Surgery, Dr. Saporito served as an instructor in dentistry and oral surgery at the university until 1948. In 1963, he became an assistant clinical professor in dentistry at the university. He is a general practitioner.

Additional teaching positions are, as consultant to Veterans Administration Hospital, East Orange, N. J., to the VA Newark regional office and to the VA Central Office in Washington, D. C., and to St. Barnabas Hospital in Newark.

**Sunday, May 14**

**8:30 p.m.**

### TRUSTEE'S REPORT

Dr. Faust was elected trustee for the Fifth District of the American Dental Association in October 1971.

Dr. Faust, who maintains a dental practice limited to orthodontics, represents dentists from Alabama, Florida, Georgia, Mississippi, North and South Carolina and Virginia.

Born in 1922 in McComb, Miss., he received his dental degree in 1944 from the University of Tennessee College of Dentistry and completed postgraduate study in orthodontics in 1951.

He is a past-president of the Forrest County (Miss.) Dental Society, the East District Dental Society, and the Mississippi Dental Association. He has been a member of the ADA House of Delegates since 1965.

# Table Clinics

**Sunday, May 14, 3:00 p.m.**

**Cardinal Ballroom**

1. **Two Way Prevention**, David F. Edwards, Raleigh.
2. **Patient Relations**, Burton Horwitz, Raleigh.
3. **Dull Doctor**, Colin P. Osborne, Lumberton.
4. **Centric Occlusion in Crown and Bridge Dentistry**, John F. Povlich, Raleigh.
5. **Splinting for Periodontally Involved Teeth**, Robert H. Sager, Raleigh.
6. **Diagnosis for Serial Extractions**, Vonnie B. Smith and Arthur Stone, Raleigh.
7. **Holland Study Club**, Jerry Wood, Selma.
8. **Parallelism in Dental Radiography**, Ramon G. Plowden, McAdenville.
9. **The Use of the Lingual Arch as a Space Maintainer**, P. E. Turner, Shelby.
10. **The Repositioning of the Gingival Attachment of the Mandibular Labial Frenum Inferiorly to Prevent or Stop Labial Stripping of Mandibular Incisors**, H. E. Plaster and H. E. Plaster, Jr., Shelby.
11. **Efficient—Effective Charting of the Mouth**, Diane B. Langevin, C.D.A., and Linda Steele, C.D.A., Charlotte.
12. **Eruption Guidance**, James H. Taylor, Asheville.
13. **Time Savers**, Jo Singleton and Barbara Hawkins, Buncombe County Dental Assistants Society, Asheville.
14. **Fixed Bridge Repair**, Frank G. Atwater, Greensboro.
15. **Biopsy: Rationale and Techniques**, E. J. Burkes, Jr., Chapel Hill.
16. **Malpractice in the Dark Room**, John Preece, Chapel Hill.
17. **Occlusion—Equilibration**, Guy E. Haddix, Statesville.
18. **Pre-Prosthetic Surgery—Vestibuloplasty With Graft**, Dept. of Oral Surgery, UNC School of Dentistry.
19. **Prevention**, Terry Johnson, Sparta.
20. **Composite Restorations**, Fred Smith and Ken Phillips, Winston-Salem.

# Projected Clinics

**Wednesday, May 17, 9:30 a.m.**

**Cardinal Ballroom**

1. **Class II Composite Restoration**, C. L. Sockwell.
2. **North Carolina Dentists' Attitude Toward Expanded Duties for Dental Auxiliaries**, Roy L. Lindahl and C. W. Douglass.
3. **Biopsy Technic and Rationale**, Jerry Patterson and E. Jeff Burkes.
4. **Malpractice in the Dark Room**, John Preece.
5. **Apical Closure Subsequent to Periapical Pathosis**, Stuart Fountain.
6. **A Vitamin C Test**, A. J. Bullard and Douglas Hill.
7. **Programs in Oro-Facial Pain Control at UNC School of Dentistry and Dental Research Center**, John M. Gregg.

# Commercial Exhibits

Monday, May 15, 9:00 a.m. to 5:00 p.m.

Tuesday, May 16, 9:00 a.m. to 5:00 p.m.

North, South & Dogwood Rooms  
& Cardinal Ballroom—Lobby

You are urged to visit the commercial exhibits. The manufacturers, dealers, laboratories and other organizations will be represented by highly qualified people who can give you helpful hints on economical and intelligent buying.

Firm Name	Booth
Astra Pharmaceutical Products, Inc., Worcester, Massachusetts.....	50
Block Drug Company, Inc., Jersey City, New Jersey.....	64
Bosworth, Harry J. Company, Chicago, Illinois.....	66
Buffalo-Novocol Dental Manufacturing Companies, Inc., Brooklyn, New York....	67
Burton Dental Laboratory, Raleigh, North Carolina.....	4
Cambiare, Ltd., Greensboro, North Carolina.....	56 & 57
Cameron-Miller Surgical Instruments Company, Chicago, Illinois.....	21
Carolina Dental Laboratory, Inc., Raleigh, North Carolina.....	39
Charlotte Laboratory, Inc., Charlotte, North Carolina.....	47
Clev-Dent, Cleveland, Ohio.....	16
Codesco/Keener Supply Division, Asheville, North Carolina.....	44
Coe Laboratories, Inc., Chicago, Illinois.....	13
Creative Ceramics, Inc., Austell, Georgia.....	12
Davies-Rose-Hoyt, Needham, Massachusetts.....	29
Dental Ceramics Laboratory, Raleigh, North Carolina.....	34
Den-Tal-Ez Manufacturing Company, Des Moines, Iowa.....	20
Denta-Scope, Miami, Florida.....	46
Dentsply International, Inc., York, Pennsylvania.....	69, 70 & 71
Janar Company, Inc., Grand Rapids, Michigan.....	41
Johnson & Johnson, New Brunswick, New Jersey.....	83
Kerr Manufacturing Company, Romulus, Michigan.....	53
Lactona Corporation, Morris Plains, New Jersey.....	30
Lee Pharmaceutical, South El Monte, California.....	14
Life-Like Ceramics, Inc., Atlanta, Georgia.....	52
Lilly, Eli & Company, Indianapolis, Indiana.....	63
Litton Dental Products, Raleigh, North Carolina.....	26 & 27
Magna Laboratories, Inc., New York, New York.....	74
Merrell National Laboratories, Cincinnati, Ohio.....	3
Midwest American, Melrose Park, Illinois.....	7, 8 & 9
Mizzy, Inc., New York, New York.....	37
National Dental Supply Company, Abington, Pennsylvania.....	65
Ney, J. M. Company, Bloomfield, Connecticut.....	28
Noble Dental Laboratory, Raleigh, North Carolina.....	45
Oral B Company, Bedford Hills, New York.....	17
Parke, Davis & Company, Detroit, Michigan.....	81
Pelton & Crane Company, Charlotte, North Carolina.....	78 & 79
Powers & Anderson Dental Supply, Charlotte, North Carolina.....	75, 76, 77 & 80
Preferred Dental Laboratory, Inc., Goldsboro, North Carolina.....	38
Premier Dental Premier Dental Products Company, Philadelphia, Pennsylvania.....	51
Proctor & Gamble Distributing Company, Cincinnati, Ohio.....	54

Professional Budget Plan, Madison, Wisconsin.....	42
Professional Sales Associates, Inc., Elk Grove Village, Illinois.....	10 & 11
Record-O-Fone, Raleigh, North Carolina.....	19
Ritter Company, Rochester, New York.....	48 & 49
Rothstein Dental Laboratories, Inc., Washington, District of Columbia.....	43
Safeguard Business Systems, Inc., Wilmington, North Carolina.....	24
Saunders, W. B. Company, Philadelphia, Pennsylvania.....	82
Siemens Corporation, Iselin, New Jersey.....	22 & 23
Squire Dental Studio, Inc., Charlotte, North Carolina.....	15
Sturgis, J. Minor Porcelain Laboratory, Atlanta, Georgia.....	40
Sullivan Laboratories, Washington, District of Columbia.....	18
Teledyne Aqua Tec Corporation, Fort Collins, Colorado.....	68
Teledyne Densco, Inc., Denver, Colorado.....	55
Thompson Dental Company, Greensboro, North Carolina.....	58, 59, 60, 61 & 62
Tincher Dental Laboratories, Inc., Charleston, West Virginia.....	84
Unitek Corporation, Monrovia, California.....	1 & 2
Vacudent Sales Corporation, Salt Lake City, Utah.....	5 & 6
Valtronic Corporation, Bronx, New York.....	35 & 36
Vick Chemical Company, Binghamton, New York.....	25
White, S. S. Company, Philadelphia, Pennsylvania.....	72 & 73
Woodward Prosthetic Company, Greensboro, North Carolina.....	31, 32 & 33

## 116th Annual Session Committee

M. L. Cherry, *General Chairman*

Darden Eure, Jr.

Otis F. Hendren

Donald D. Culp

L. P. Megginson, Jr.

Robert B. Litton

**Arrangements:** Darden Eure, Jr., chairman; David H. Simpson, J. Sidney Hood, William D. Burns, Kenneth D. Owen.

**Projected Clinics:** James A. Privette, chairman; H. V. Murray, Jr., William A. Mynatt, Robert Caviness, Wayne H. Ridout, Wallace Honeycutt.

**Table Clinics:** Wilburn A. Davis, chairman; Eldon H. Parks, Neal Sheffield, K. L. Johnson, Carle W. Mason, Jr.

**Commercial Exhibits:** E. A. Pearson, Jr., chairman; James E. Graham, Jr.

**Entertainment:** Donald D. Culp (Entertainment and Dance); Robert B. Litton (Banquet).

**Monitor:** Otis F. Hendren, chairman; Thomas H. Sears, Jr., William R. Henshaw, Joseph W. Farrar, Claude W. Herndon, C. Jay Harris, Jerry F. Wood, Robert W. Wilson, Martin H. Murphy, Richard P. Belton, William F. Yost, Gerald P. Turner, Michael L. Collins, Johnnie D. Hodges, Amos J. Bullard, Jr., T. Fredrick Blume, James B. Hancock, John B. Hardy, Samuel I. Smith, H. F. Wilkins.

**Auxiliary:** M. G. Delbridge.

**Program:** William A. Mynatt, chairman; J. O. Thorpe, Mitchell W. Wallace, Baxter B. Sapp, Jr., David H. Freshwater, Kenneth M. Ray.

**Publicity:** L. P. Megginson, chairman; J. B. Roberson, Frank Pattishall, Burton Horwitz, Garland R. Homes.

**Scientific Exhibits:** Cecil R. Lupton, chairman; H. V. Murray, Jr., C. E. Crandall.

**Sports:** John H. Dixon, chairman; William C. Bean, Robert H. Poole, Jr., E. P. Williams.

# NORTH CAROLINA DENTAL ASSISTANTS ASSOCIATION

## TWENTY-SECOND ANNUAL SESSION SHERATON MOTOR INN, SOUTHERN PINES

May 14-16, 1972

### PROGRAM

#### Sunday, May 14

- 8:30 Breakfast Honoring NCDAA Past Presidents**  
**10:00 First Session General Assembly**  
President Aileen Croom Presiding  
**2:00 General Session**  
Welcome: Dr. Joseph Johnson, President-Elect NCDS  
Greetings: Mrs. Priscilla Levine, NCDHA  
Response: Mrs. Betty Chandler, NCDAA  
"Advance — with Education": Mrs. Iva Coulter, President ADAA  
Program Chairman: Mrs. Wilma Wilson, President-Elect, North Carolina Dental Assistants Association  
"The Future—Our Concern?": Mrs. Helen Merideth, Trustee, ADA Fourth District  
"How to Treat Your Patients Feelings": Mr. Chuck Ridge, NCDAA President's Address: Miss Aileen Croom  
**9:00 "The Happy Hour" Honoring ADAA Guests—Southern Pines Elks Club**  
(Tickets compliments NCDAA)

#### Monday, May 15

- 9:00 Second Session of General Assembly**  
President Aileen Croom Presiding  
**10:30 Educational Forum**  
Dr. William Hinson, High Point, "Interesting Oral Surgery Patients"  
Dr. Glen Hunt, Greensboro, "Dental Plaque Disease — Here Today, Gone Tomorrow?"  
Dr. George Mayo, III, Goldsboro, "The Role of the Auxiliary in Preventive Dentistry"  
**12:45 Balloting**  
**7:00 "Azalea Ball" Banquet**, Honoring NCDAA President Aileen Croom, Southern Pines Elks Club  
**9:00 Dance—Southern Pines Elks Club**

#### Tuesday, May 16

- 9:00 Coffee and Donuts Hour for Students**  
**10:00 NCDAA Table Clinics**  
**2:00 Third Session General Assembly**  
Presentation of Awards  
Installation of Officers



Mrs. Lawrence Paschal  
Vice President



Mrs. William D. Wilson  
Recording Secretary



Mrs. Thomas Baykin  
Corresponding Secretary

## NORTH CAROLINA DENTAL AUXILIARY 1971-1972



Mrs. M. G. Delbridge  
President



Mrs. T. Hicks Hamrick  
President-Elect



Mrs. Wallace B. Butler  
Treasurer



Mrs. Dan J. Floyd  
Historian



Mrs. David Freshwater  
Parliamentarian

# NORTH CAROLINA DENTAL AUXILIARY

## TWENTY-SECOND ANNUAL MEETING

### THE CAROLINA, PINEHURST

May 14-16, 1972

#### PROGRAM

##### Sunday, May 14

1:30	Registration Desk Opens	
5:30	Social Hour .....	Poolside
8:30	N. C. Dental Society General Session.....	Cardinal Ballroom (Auxiliary members invited to attend)

##### Monday, May 15

8:30- 9:30	Golf Tournament followed by Lunch	Pinehurst Country Club
8:30	Tennis Breakfast.....	Hotel Dining Room
9:30	Tennis Tournament followed by Lunch	Pinehurst Country Club
3:00	Executive Board Meeting.....	Azalea Room
8:30	Annual Meeting .....	Azalea Room (Business, election and installation of officers, introduction of new members, fun and fellowship, entertainment, door prizes)

##### Tuesday, May 16

8:30	Past Presidents' Breakfast.....	Hotel Dining Room
8:30	Tennis Breakfast .....	Hotel Dining Room
9:00	Registration	
10:00-11:30	Crafts Show .....	Azalea Room (Display of crafts made by Auxiliary members)
10:30	Bridge Party.....	West Porch
12:30	Annual Luncheon.....	Foxfire Gun and Country Club (Honoring new members, wives of senior dental students, and special guests) Speaker: Mr. Charles Dunn, Director, State Bureau of Investigation
	Outgoing and Incoming Executive Board Meeting	
	(Immediate following luncheon at Foxfire)	
7:00	Annual Banquet.....	Hotel Dining Room
8:30	Entertainment and Dancing.....	Cardinal Ballroom

##### Wednesday, May 17

No scheduled events

# NORTH CAROLINA DENTAL HYGIENISTS' ASSOCIATION

## TWENTY-FIFTH ANNUAL MEETING

SOUTHERN PINES, N. C.

May 14-16, 1972

### PROGRAM

#### Sunday, May 14

10:00	<b>Executive Council Meeting</b> .....	Holiday Inn
11:00- 1:00	<b>Registration</b> .....	Elks Lodge
1:00	<b>Opening Session</b>	
	Call to Order	
	Invocation	
	NCDA Greetings	
	NCDAAGreetings	
	ADA Auxiliary Greetings	
	NCDHA's Advisors Greetings	
	District Trustee Report	
	Introduction of Mrs. Diane McCain, ADHA President	
3:00- 5:00	<b>Scientific Session</b> .....	Elks Lodge
	Dr. Dennis Stacey: "Psychology of Patient Motivation"	
7:00	<b>Social Hour</b> .....	Holiday Inn
	Games and Fun for Everyone	

#### Monday, May 15

8:00- 9:00	<b>Registration</b> .....	Elks Lodge
9:00-10:00	<b>Business Meeting</b> .....	Elks Lodge
	Reading of Minutes	
	Reading of Committee Reports	
	Reading of Officers Reports	
10:00-10:30	<b>Address:</b> Mrs. Diane McCain, ADHA President	
10:45-12:00	<b>Scientific Session</b>	
	Dr. Gary Smiley: "Dental Research"	
12:00- 1:00	<b>Luncheon</b> .....	Elks Lodge
	Presentation of Table Clinics Awards	
2:00- 3:00	<b>Table Clinics</b> .....	Elks Lodge Bar
3:00- 5:00	<b>Business Session</b> .....	Elks Lodge
	Election of Officers	
3:00- 5:00	<b>Jr. Members Meeting</b> .....	Holiday Inn
5:30	<b>Party Honoring Jr. Members</b> .....	Holiday Inn
	(All NCDHA Members Please Come to Meet and Honor These Girls)	

#### Tuesday, May 16

9:00-10:30	<b>Exhibits</b> .....	The Carolina
10:30	<b>Unfinished Business</b> .....	Elks Lodge
	Installation of Officers	
12:00	<b>Executive Council Meeting</b> .....	Holiday Inn

# Items of Interest (cont.)

## Endodontics Texts Needed

The Department of Endodontics of the UNC School of Dentistry is in need of some of the older texts on Endodontics. Readers who have copies of any of the following texts that they would care to donate to the Department of Endodontics please contact Dr. Stuart B. Fountain, UNC School of Dentistry, Chapel Hill, N. C. 27514.

1. Crane, A. B., *A Practicable Root Canal Technic*, Lea and Febiger, Phila., 1920.

2. Hall, Edouard M., *Pulpless Tooth Problems*, Detroit (Kerr) Dental Mfg. Co., 1928.

3. Grossman, L. I., *Root Canal Therapy*, Lea and Febiger, 1st Edition 1940, or 2nd Ed. 1946, or 3rd Ed. 1950, or 4th Ed. 1955 .

4. Castagnola, L. and Orlay, H. B., *A System of Endodontia*, Pitman Medical Publishing Co., Ltd., London, 1956.

5. Coolidge, E. D. and Kesel, R. G., *Endodontology*, Lea and Febiger, 1956.

6. Healey, H. J., *Endodontics*, St. Louis, C. V. Mosby, 1960.

7. *Transactions of World Conference on Endodontics*, Philadelphia, 1953, Printed by Stephenson Brothers.

## Dr. Harrell Attends Conference

Dr. James A. Harrell of Elkin, secretary-treasurer of the NCDS, represented the Society at the 22nd Annual Management Conference at ADA Headquarters in Chicago, June 7-9. Topics ranging from the planning and conduct of annual sessions to state dental political action committees were discussed.

Copies of Dr. Harrell's full report on the Conference are available from the Central Office.

## Conference on Preventive Dentistry

Dr. M. W. Aldridge of Greenville attended the Second Conference on Practice Administration at ADA Headquarters in Chicago, September 9-10, 1971.

The major objective of the Conference was to explore the involvement, responsibility, and commitment of organized dentistry to increasing the emphasis on preventive practice.

Copies of Dr. Aldridge's report on the Conference are available from the Central Office.

## State Extends Medicaid Contract with NCBCBS

The N. C. Department of Social Services has extended its contract with North Carolina Blue Cross and Blue Shield for the administration of Medicaid claims. Previously, the Department of Social Services announced that the contract would not be renewed when it expired December 31, 1971.

During 1972 NCBCBS will continue to perform the same functions that it has for the Department of Social Services during the past two years.

During the first several months of 1972 the Board of Social Services will give further study and consideration as to whether the State should take over the administration of the Medicaid program. In addition, the Department of Administration and the Department of

Human Resources will also examine the question, and any decision of the Department of Social Services will have to have their approval.

The Department of Human Resources was created by the 1971 Legislative Act to reorganize state government and has under its jurisdiction some 30 commissions and divisions, including the Board of Health, the Department of Mental Health, the Department of Social Services, the Blind Commission, and the Medical Care Commission. Governor Scott has appointed Dr. Lenox D. Baker of Durham to head the new department.

### **Illinois Dental Service Starts Dentists' Program**

Illinois Dental Service is offering a comprehensive prepayment dental care program to dentists, their families and office staffs. Enrollment will be through the component societies of the Illinois State Dental Society.

"Since organized dentistry has pioneered prepayment dental care programs and today holds the leadership position in this field, it makes only good sense for dentists to set a sound example and join such programs themselves," said Dr. John E. Zur, IDS executive vice-president.

An 80 per cent or more enrollment of the members of a component society will be needed to place the program into operation, he added.

### **Prevention and Control Of Periodontal Disease**

The best weapon against periodontal disease is oral cleanliness. So concludes Dr. John D. Suomi of

the Division of Dental Health, National Institutes of Health, U. S. Department of Health, Education, and Welfare, after a study of some 300 sources from the scientific literature on periodontal disease.

Dr. Suomi has published the results of his literature review in *The Journal of the American Dental Association*, Volume 83, December 1971. In his article, "Prevention and control of periodontal disease," he notes that toothbrushing is the method most commonly recommended for patients to use at home to remove oral debris and plaque from the teeth. No one method has been shown clearly superior to others; and thoroughness of cleaning by careful and correct application of any brushing method is more important to the maintenance of periodontal health than the method itself.

Recommended optimum frequencies for professional oral prophylaxes for people of different ages and with varying degrees of periodontal disease have not been established. A patient should receive prophylaxes at a frequency consistent with the rapidity with which deposits are seen to form, with the patient's oral hygiene habits and with his periodontal condition.

The pros and cons of numerous preventive procedures, which scientific literature has explored, are discussed in the *JADA* article; and Dr. Suomi also addresses himself to some of the procedures involving new plaque-inhibiting agents, which are now being developed and tested and which offer promising approaches to the prevention and control of periodontal disease.



### **North Carolina Dentists Enjoy Hawaii**

Pictured above are Drs. Ben Baker, Frank Locke, Ralph Coffey, Frank Loo and Larry Dorton. Dr. Locke is president of the Hawaii State Dental Association and Dr. Loo is chairman of the Insurance Committee for the HSDA. During the recent Aloha Carnival trip to Hawaii by the NCDS, Ralph Coffey took the opportunity to meet with the Hawaii State Dental officers to review the ADA Professional Protector Plan. He is chairman of the ADA Insurance Council. Larry Dorton was coordinator for the Aloha Carnival which was unbelievable fine in its execution. From start to finish, the 171 NCDS people who participated were royally entertained. Larry Dorton deserves a real vote of thanks from the Society for his efforts.

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200.00	100.50	114.50	164.50	228.50	282.50	
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<div>Plan L-65</div>		Maximum Accident Benefits Lifetime	Maximum Sickness Benefits To Age 65			
Weekly Benefits		SEMI-ANNUAL RATES				
	Under 30	30-39	40-49	50-59	60-69	
\$300.00	\$184.50	\$211.50	\$289.50	\$388.50	\$421.50	
250.00	154.50	177.00	242.00	324.50	352.00	
200.00	124.50	142.50	194.50	260.50	282.50	
150.00	94.50	108.00	147.00	196.50	213.00	

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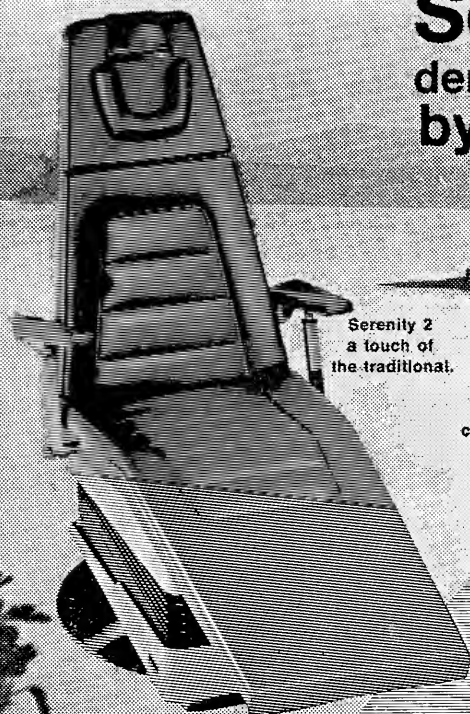
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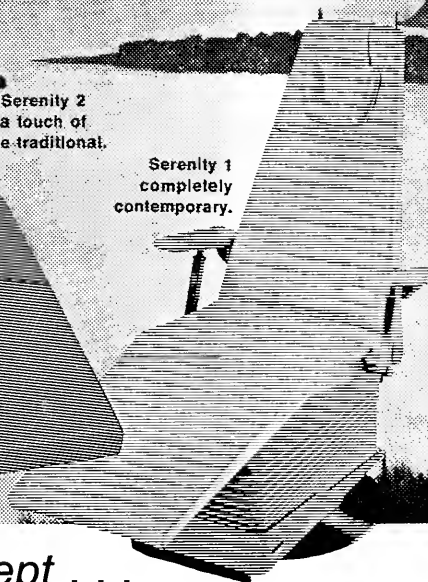
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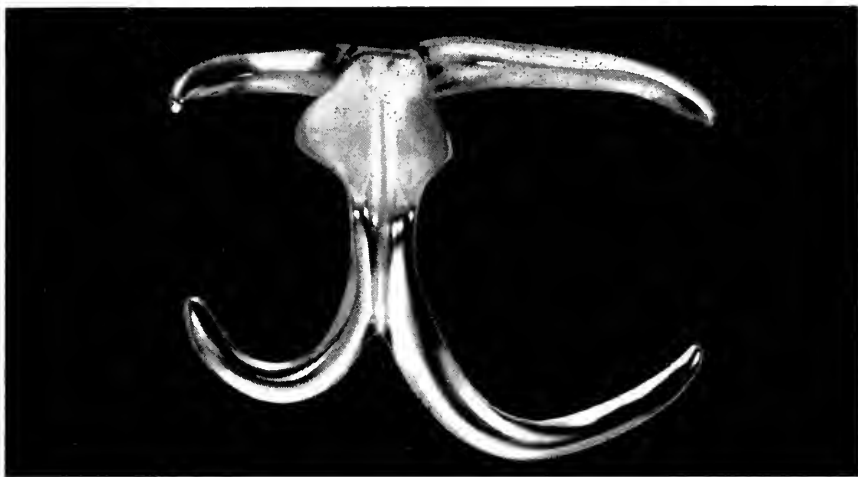
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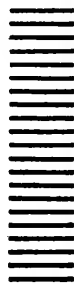
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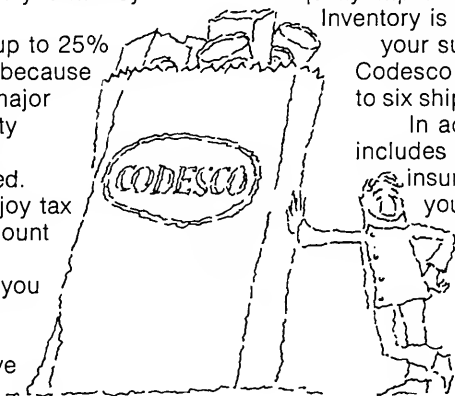
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**IN  
THIS  
ISSUE**

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*Second District, Charlotte, Sept. 24-26*

*Third District, Greensboro, Oct. 7-9*

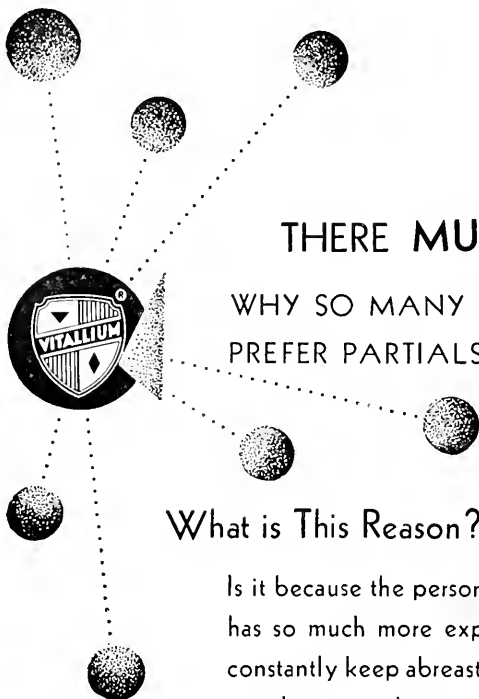
*Fourth District, Raleigh, Oct. 13-14*

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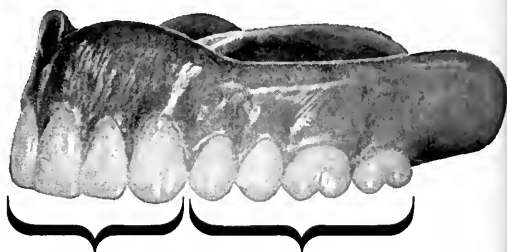
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# The President's Page



THE MEMBERS of the North Carolina Dental Society appreciate the great time and effort which Ben Baker has given as the editor of this JOURNAL. He has been most diligent in the performance of the many duties with which he has been confronted and has given much of himself to this task. I would like to express to Ben a most sincere "Thank you" for the fine job which he has done.

It is with pleasure that we acknowledge Jack Shankle as the new editor of this publication. Jack comes to this position with much experience and expertise but he needs your interest, cooperation, and constructive suggestions for the JOURNAL to be a viable vehicle of communication for the members of the N. C. Dental Society. I am sure that you will give him your enthusiastic support.

The Standing Committees of our Society carry much responsibility in many areas of work. The men who have accepted appointments to these committees are aware of the root meaning of the word committee. They have committed themselves to jobs which are not always glamorous and are frequently controversial but are most necessary if the N. C. Dental Society continues to move forward as a strong organization to serve the needs of both the patients and the dentists in this state.

At long last we have a Peer Review Manual which is ready and will be used as peer review if necessary.

Much preparation and work has been done in order for the Delta Dental Corporation to begin its operation. We wish for it much success as it gets underway. It will take time for this organization to be truly effective. The men who are working on this committee are to be commended for their efforts.

A Political Action Committee is being organized. This committee will need your personal and financial support. In this age of massive health legislation our profession must be vitally concerned and involved and take the necessary steps to make our voices heard to protect our patients and ourselves.

This month there will be a meeting of the Inter-Agency Committee which is composed of the Executive Committee, representatives from the U.N.C. Dental School, the State Board of Dental Examiners, the presidents of the five districts, the Director of the Division of Dental Health,

the Chairman of the Long-Range Planning Committee, and the President of the Spurgeon Dental Society. This group will discuss problems that effect all of us and hopes to resolve some of these issues.

Betty and I are looking forward to attending the District meetings this fall. Meanwhile, if you have any suggestions or concerns please feel free to contact me about them. Remember that we don't all have to agree on every issue just so long as our intentions are honorable and we have respect for each other's viewpoint. If we do this we will arrive at positions with which we can live.

JOSEPH M. JOHNSON

---

# **Editorials**

*The editorial below appeared in the March-April, 1972, issue of the ASDC "Journal of Dentistry for Children." It is reprinted with the permission of the author, Dr. George W. Teuscher, Editor of the "Journal of Dentistry for Children."*

## **THE PREVENTION PENDULUM STILL SWINGS**

The present efforts to promote professional and public interest in the prevention of oral disease appear to involve larger percentages of people than did previous attempts. Many of us have seen glowing enthusiasm for prevention engendered in other eras and have seen it wane to states of almost total darkness. To believe that the same fate will not befall the current enthusiasm would be to defy the historical reluctance of people to change their life habits. No reliable evidence exists to give us confidence in the individual's ability to so discipline himself that the personal requirements for the prevention of oral disease can be met on a sustained basis. We have yet to learn how to apply modern psychological knowledge to such common problems as convincing and teaching an individual to accept and apply proved techniques of disease prevention over long periods of his lifetime. The failure of a great majority of weight reducers to stay reduced is glaring evidence of the losing fight most people wage with dominant drives. An unconscious force keeps us in bondage to our habits.

My remarks are not meant to suggest that efforts in prevention are futile. I do believe, however, that they express realism. They are intended to highlight the need for learning much more about the psychological and emotional sides of people, individually and sociologically. Evidence in point is the failure of substantial segments of the population, for example, to adopt fluoridation of community water supplies in the interest of preventing dental caries, in spite of the impressive research to support it.

Psychologists have long maintained that money is the strongest incentive to accomplishment. In the matter of dental disease, however, one must doubt that even money bears much influence on what people do about prevention. A perusal of the very large expenditures for health care in this country should be sufficiently frightening in its effect on intelligent people to make prevention a very attractive avenue to travel.

Consumer expenditures for all types of health care in 1970 amounted to \$47,268,000,000 (Survey of Current Business, U. S. Department of Commerce). Of this total, \$12,441,000,000 were paid to physicians and \$4,383,000,000 to dentists. Privately controlled hospitals and sanitariums received \$17,147,000,000 from private consumers. It is interesting to note that the only item of medical care to take an ever-increasing portion of the health dollar has been the hospitals. In 1970 this amounted to 36.3 percent, an all-time high. In 1970, dentists received 71 cents out of every \$100 that consumers in the United States spent for goods and services.

This statistic represents a per capita expenditure for dentistry of \$21.74 in 1970.

The significance of these costs is that the American public apparently is willing to bear them in lieu of adopting prevention programs, which presumably should cost considerably less. Because people seem to be more responsive to dollars than to personal well-being, the monetary costs of treatment as opposed to prevention have been emphasized in preference to explaining the tremendous personal benefits to be derived from the prevention of disease. We should emphasize, however, cost and personal benefits.

The many men and women who have devoted their services to promoting programs and techniques of prevention are to be commended for their dedication. Their call for more serious attention to the subject in practice and in dental education is justified and deserves positive and vigorous support from all sectors of the dental profession. All health professions persons should be aware of their plea and all should be strong and active proponents of their teachings.

The important reason for supporting prevention is that it is the only course of procedure in health matters that makes any kind of sense. We should recognize, however, that we are operating in a tangled maze of emotion, insufficient knowledge, misunderstanding, and neglect that defies the keenest and most intelligent minds. In a way, that makes the challenge the more interesting. We should attack the problem knowing the nature of what we face. If we do not, the pendulum will swing to the darkside once again.

### **NEW ZEALAND DENTAL NURSE PLAN PROPOSED IN THE UNITED STATES**

At the conference of Dental Examiners and Dental Educators in Chicago in February, 1972 Dr. John Ingle, Dean of School of Dentistry USC recommended a plan for the solution to dental problems of the children in the United States. The meeting was attended by some of the finest minds in dentistry in the U. S. Dr. Ingle's remarks were received by the group in an atmosphere of less than universal acceptance. Some agreed with him while others violently opposed him.

I have read Dr. Ingle's paper. It is obvious that he is serious and it is obvious that his sincere interest is to make dentistry available for all children in the United States. His proposal would unfortunately fall short of maintaining the quality of service now being rendered to children in the U. S. It threatens, if implemented, to jeopardize every dental practice and dilute the standards of excellence for dental service which have been built up in our country.

The following quotation from Dr. Ingle's paper explains briefly the proposed program:

*... "What I am proposing is a nationwide dental health program home-based in the nation's elementary schools. Under the supervision of the profession, a totally new category of dental papaprofessionals,*

*who might be called "School Dental Therapists," backed in turn by a corps of assistants, will be responsible for a well organized and aggressive program in prevention and treatment. The school dental therapists will be trained specifically and limited to restoring carious teeth, treating initial periodontal conditions, extracting deciduous teeth and guarding the integrity of the dental arches by space maintenance. They will be trained to make their own examinations, diagnosis and treatment plan. They will be thoroughly trained to make their own injections and carry out a full scale preventive program. In all of this they will be remotely supervised by the dental profession and will be assisted by the school dental therapist assistants." . . .*

Dr. Ingle bases his proposed program on the "success" of the prototype New Zealand Dental Nurse Corps. He offers statistical evidence of the efficacy of the program in New Zealand when compared to the number of treated children there with children in the U. S. He indicates that we are significantly behind in our treatment for children. His statistics are impressive but they should not stop where he stops. They should continue into adulthood to show the relative oral condition of New Zealanders compared to U. S. adults. They should reflect random samples of quality of treatment and dental awareness between the populations of the two countries' citizens who receive care. They should show follow up studies as to whether the dental nurse program actually provided better adult dentitions.

It is the opinion of this editor that his proposed recommended education and training program is insufficient. There are too many areas in basic science which students must know for definitive treatment of patients. A program with less than two years training cannot possibly provide expertise in all these areas. If they could why not reduce the training and education of the dentist to do the same thing. Granted a student can be trained to prepare and restore a tooth in a short time. If filling teeth and teaching home care is the basis of this program why not have several expanded auxiliaries with each dentist to provide the services. Unsupervised practice or remote supervision of therapists is contrary to everything we have stood for in this country relative to quality control, yet it is recommended for this program. Dr. Ingle recommends no rigid admission requirements and no basic length of education for trainees. This supposedly opens doors for trained people such as military enlisted personnel, dental hygienists and assistants to move up to the therapist level. In order to insure quality service for patients this does not seem consistent with good practice. He recommends no board examination when training is completed, rather, an onsite evaluation. How many could slip through and do significant damage to patients before being discovered. Dr. Ingle points out that there are 85,000 elementary schools in the U. S. where therapist should be in residence. To train 85,000 therapists for two years would cost a minimum of 850 million dollars. In addition these individuals salaries must be set above that which most hygienists earn privately, in order

to attract better prepared personnel. Consequently based on a \$12,000 salary, therapists' salaries alone would cost 1 billion 20 million per year. Each therapist should have at least one assistant and each therapist should be able to treat about 750 patients (twice the New Zealand work load) according to the proposal. To do this, it appears that two auxiliaries should be hired for each therapist. The total salary structure would therefore be in excess of 2 billion. A properly outfitted operatory for dentistry today runs in the \$15-\$20,000 range for first class equipment. 85,000 operatories at less than 1/2 of private costs would further increase the cost of funding a program of this type. Supplies, materials, and maintenance also must be calculated. It becomes apparent that the total package of monies necessary to provide a program of this type would be almost prohibitive and can be better spent in other areas to provide service for all in the U. S. While cost for health should not be a determining factor its obvious that this kind of cost is prohibitive.

In short the proposal has significant jeopardy for private practitioners while not really solving the problems of dentistry for children. It glibly ignores the specialty of Pedodontics while making sure to protect the specialty of Endodontics. In the recommendation all permanent tooth root canals are referred to private offices. It should occur to Dr. Ingle that the most difficult area of diagnosis for space maintenance occurs in the mixed dentition stage which encompasses the elementary school age. Yet he recommends that therapists routinely place space maintainers.

It is hoped by this editor that serious consideration is not given to the program. Surely there are other means in our country which can meet the needs of dentistry and not prostitute the practice of dentistry in the process. To mention a few; national fluoridation laws, a national prevention program, the ADA proposed children's dental health program, expanded auxiliary duties, and gifted dental students graduation at less than four years training.

I do not in any way imply disrespect to Dr. Ingle nor do I question his motives in the dental therapist proposal. What is good for one country may not be good for another. We found this out trying to bring democracy to Southeast Asia. I firmly believe that if other educators would think constructively and stick their necks out as Dr. Ingle has with proposals for meeting the demands of dentistry we would be able to solve these problems. I admire Dr. Ingle for his fortitude and I agree with him about our dental problems. I disagree with him vehemently about the solution.

B. R. BAKER

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# Finishing and Polishing Restoratives

By Wilmer B. Eames, D.D.S.  
Atlanta, Georgia

The advantages of finishing and polishing restoratives in the mouth may seem obscure to the patient, but to the dentist, it is a matter of pride and integrity. Since the ability to polish a restoration culminates a series of highly skilled performances, the fruits of his labor may well be fulfilled at this time.

The obvious reasons for finishing a restoration are well-known: to inhibit corrosion in the amalgam, to perfect margins in the inlay, and to improve the esthetics and surface texture of the anterior silicate or composite. None of these reasons may be complete in themselves. Each material will be discussed, first on the basis of the need, and second, the technique and probability of success.

## Amalgam

An amalgam well done, deserves a proper finish. Polishing may be done after 6 hours<sup>1</sup> or longer. Polishing will usually prevent corrosion, but the unpolished proximal surfaces, and the internal surfaces which are exposed to fluids of the dentine, may corrode and discolor. Varnishes will inhibit the latter to a large degree.

It is quite likely that excess occlusal amalgam will be present despite careful carving, because of the

natural inclination of the planes of the cusps, creating a friable acute angle. Cavity margins and landmarks are obliterated when excess amalgam is condensed, frequently leaving gross occlusal excess. Figure 1.

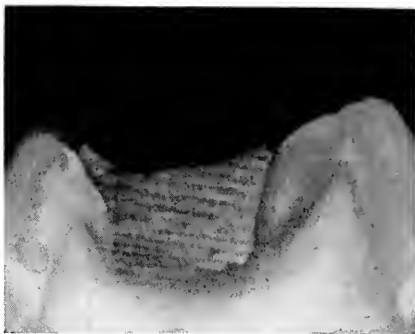


Figure 1. Lips of occlusal excess fracture to leave black margins. Cavity outline landmarks are covered when excess amalgam is condensed.

Excess expansion, attributed to contamination, may not in itself be an important factor. Studies<sup>2</sup> have shown that the expansion is not as significant as is the loss of strength and a tendency to corrode when amalgam is condensed into a wet field.

Marginal deflection has been theorized to be due to mercurioscopic expansion<sup>3</sup> caused by the attraction of free mercury at the margins, causing a unilateral expansion.

High residual mercury may cause marginal weakness and fracture. This may be largely eliminated by employing alloy/mercury ratios of predetermined amounts,<sup>4</sup> resulting in minimal ultimate residual mercury.

Dr. Eames is Professor of Operative Dentistry, Emory University, School of Dentistry. Presented at the Twenty-Eighth Postgraduate Dental Seminar. Presented in the Nashville District October 12-13, 1970. Reprinted by permission from the *Journal of the Tennessee Dental Association*; January, 1971; Vol. 51, No. 1.

TO BEGIN the finishing procedure, a large round bur can be used safely at slow speeds, to safely chip away excess without damaging enamel rods. Recently, multishaped 12-bladed burs\* have been described<sup>5</sup> which will produce a reasonably smooth finish clinically (Figure 2), when used at reduced speeds. High speed cutting unnecessarily removes enamel, and may not produce an acceptable finish.



Figure 2. 12-bladed carbide finishing burs produce reasonably smooth surfaces clinically, when used at reduced speeds.

Gold knives or scalers will remove proximal flash smoothly and quickly, after which discs may be used with caution, taking care to roll the instrument to prevent flattening the normally rounded embrasure tooth morphology.

Small tapered carborundum stones, or the previously mentioned finishing burs, will smooth and shape surface discrepancies. Care must be taken to minimize the abrading of the enamel, because the rods are sometimes irregularly positioned and may fracture away. At this time grooves and anatomy can be refined.

**The most useful finishing procedure** after initial smoothing, is the open contra-angle prophylaxis brush with copious amounts of wet pu-



Figure 3. The edge of a brush with copious amounts of wet pumice provides the most efficient finishing procedure, without destroying carefully carved anatomy.

mice, (Figure 3), placing the *edge* of the brush into the grooves for maximal effect. The capacity of a **pointed** brush is greatly limited, because of its small circumference and its tendency to become rounded, producing saucer-shaped sulci. Pumice cuts rapidly and, by carrying it frequently from the container to the amalgam surface, the open brush will smooth the surface without destroying anatomic integrity.

Rubber cups can be used in proximal areas, but with extreme caution, to prevent overheating. Rubber abrasive wheels should not be used to polish amalgam at any time. Experiments with the thermocouples embedded in amalgam specimens<sup>6</sup> produced a temperature build-up in only a few seconds with rubber wheels, that softened amalgam and produced a dull, rough surface. Brushes produced only a few degrees increase and are considered to be safe.

A final high luster, befitting a fine amalgam restoration, can be obtained by using a wet, soft wheel brush with *wet* tin oxide, rotating against the tooth toward the mouth, to help prevent splattering. Several polishing agents are available com-

mercially. The use of *zinc* oxide in the form of a paste will also produce a high polish, although more slowly. Or, the use of zinc phosphate cement powder mixed with water will give satisfactory results.

It is important to remember that the preliminary steps of grinding, shaping and smoothing, with the subsequent thorough pumicing, are highly important before attempting to produce a high polish. At its worst, a high polish reflects scratches, pits and discrepancies not otherwise noticeable.

The polished amalgam (Figure 4) retains its integrity, is admired by the patient, and is a pleasure and a pride that you can well afford.



Figure 4. A high polish is befitting a fine amalgam.

### Cast Gold

The finishing and polishing of a gold casting involves two distinct factors: (1) the correcting of minor marginal discrepancies, and (2) smoothing and polishing the surface. These factors are almost entirely unrelated, and will be discussed separately.

#### *Cavo-surface margin finishing*

The perfectly fitting inlay has not yet been made. The width of the interface between the tooth preparation and the casting is of clinical

importance because of the solubility of the cementing medium. If this space at the margin is not excessive, it may be minimized by moving gold with burnishing or abrasive instruments.

The washing-out, or degree of dissolution of cement at the margins appears to be directly related to the width of the cement at the interface. Assuming that there are no perfectly adapted margins, some minimal degree of space provides a clinically acceptable condition that will dissolve only superficially. It has been theorized that zinc phosphate cement dissolves up to the saturation of the saliva in the crevice, and that the wider the crevice, the greater the possibility of dissolution of the cement through the exchange of fluids by capillary attraction or by washing out mechanically.

When a casting is placed into, or upon a prepared tooth, the degree of fit is usually determined by the experience and the judgment of the operator. What appears to be excess, may only be an incomplete seating of the casting, due to internal discrepancies. This excess nearly always exists **to a degree**, and the margin should be adjusted with abrasive instruments to an acceptable smoothness, compatible with the character of the adjacent tooth structure. The limit of an acceptable discrepancy may be less than 40u and the average operator can probably readily detect this much of an opening, with the fine of a sharp explorer.

#### *Burnishing gold*

A study has shown that if minor discrepancies exist at the interface, after the preliminary abrasive adjusting, a cavosurface margins of

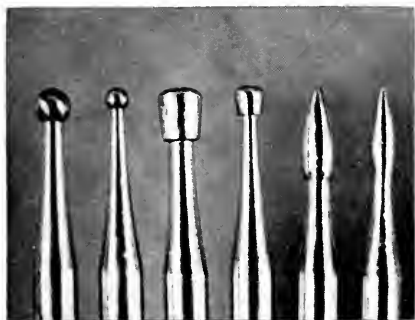


Figure 5. Smooth burnishing burs move marginal gold up to 70u.

gold can be burnished or moved with **smooth rotating** burnishing instruments\* (Figure 5), in the form of a strong, well-formed wedge-shaped lip (Figure 6). This lip extends from the casting, up to 70u both horizontally and in depth. This occurrence is an apparent internal adjusting procedure to which the individual gold grains deform and form slip lines in the grain itself, producing a work-hardening of the distorted area, (Figure 7).

Contrary to techniques which are commonly taught, it was found that when abrasive instruments are used to finish margins, *i.e.*, the carborundum stone, finishing burs and abrasive rubber wheels, the movement of gold produced a granular, soft lip (Figure 8), which is easily broken or deformed during finishing and cementation. The movement of gold with stones and discs is relatively shallow and ineffective, and should be followed by more efficient **smooth** rotating instruments, prior to cementation.

Attempts to 'close' margins after cementation, cannot be successful, because the space, or interface, is filled with cement, and there is no

place for the formation of the burnished lip to occur.

It was also found in the study of the movement of gold,<sup>7</sup> that Type III ("C") gold produced an almost equal lip formation as Type II ("B") gold when smooth rotating instruments were used, but that the base attachment was more friable with the hard gold when stones were used. This movement with a 'hard' gold can be accounted for from a

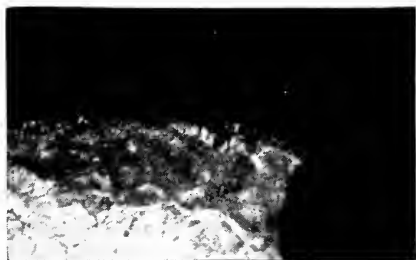


Figure 6. Well-formed marginal lip of gold developed with smooth rotating burnishing instruments.

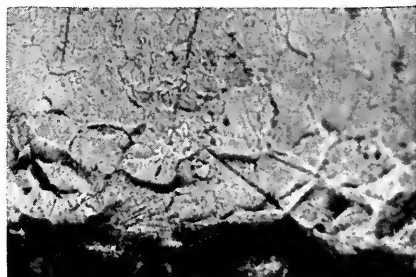


Figure 7. Gold movement and distortion as influenced by burnishing. Slip lines are seen in individual grains.



Figure 8. A soft, granular lip of gold, produced by abrasive instruments, is easily broken during finishing and cementation.

\* RA Burnishing Burs, Premier Dental Products Company.

metallurgic standpoint, but has generally not been acknowledged in clinical dentistry heretofore.

It must be pointed out, that many inlays would not require the depth and breadth of gold movement described here. It is possible that the fragile margin produced by the abrasive instruments is so minute in a precision casting as to be clinically insignificant. If a crevice cannot be detected visually or by tactile examination, the casting margin is probably clinically acceptable.

### *Polishing gold*

The scrupulous and meticulous care that is possible in fabricating the gold inlay, places it as potentially the most successful restoration that we are now able to produce. Long-range clinical observations (Figure 9) show the inlay to maintain good surface and marginal in-



Figure 9. A 24-year old inlay showing a high degree of marginal integrity. Gold is inherently more compatible to the rigors of the mouth environment.

tegrity because the metal itself is inherently more compatible to the rigors of the mouth environment. It might also be said without reservation, that if the inlay technical rules were violated as commonly as with the silver amalgam, the incidence of failure would far exceed those of the reluctant amalgam.

The actual polishing of the gold casting is very similar in most respects to the amalgam, starting with smoothing and shaping instruments, and finishing with successively less abrasive materials. If finishing is done in the mouth, before cementation, the use of pumice is the most rapid means of providing a satin finish. If done in the laboratory, the use of pumice is difficult excepting on the lathe, because of splattering, and the rubber abrasive wheels are usually used, although somewhat less efficiently. In the laboratory the use of rouges is commonly the most effective, while in the mouth the final polish is best produced by using a paste of tin oxide or aluminum oxide. The use of zinc oxide can be employed, but the time required is somewhat longer than that of faster cutting abrasives.

A highly polished and anatomically correct gold casting is the mark of the skillful operator, and it is most important that the technical steps of cavity preparation and casting procedures command the complete understanding and observation in meticulous detail otherwise, the highly polished gold casting is an illusion, and obscures the frailties and the potential failures from which the patient, and the profession, will suffer.

### **Silicates, Resins and Composites**

These materials are the most difficult of the restoratives to finish and polish satisfactorily. Neither the silicate nor the filled resins (composites) will retain a polish at all. This is because the gel of the silicate, and resin of the composites, have little resistance to abrasion. And, the gel of the silicate is highly

soluble. The unfilled methylmethacrylate resins will not retain a true polish, but appear clinically smoother.

### *Silicates*

Because the silicate restoration is extremely soluble within the first few hours, and also exhibits poor edge strength, it must be well-protected from mouth fluids with a water-proof varnish for several hours, and the margins must **not** be finished at the same sitting. Any attempt to do so will only result in marginal ditching.

At a subsequent sitting, the excess flash can be best removed with slowly rotating non-dentated fissure burs, carefully cutting with the silicate and the enamel to avoid chipping into the cavosurface margin. Gingival excess can be removed judiciously with scalers, and abrasive strips used below the contacts. Rolling a slowly rotating abrasive disc to avoid flattening the surface, will produce the ultimate silicate surface.

The surface left by the celluloid strip has been described as the best surface that can be obtained. Profilometer surface roughness experiments bear this out, but the gel surface is highly susceptible to the mouth atmosphere of acid producing plaque. And even the unsuspecting commonly used dentifrice will quickly remove the luster of the strip after a very short time.

The silicate surface remains essentially rough for the life of the restoration, baring only the protruding particles of the silica.

### **Methylmethacrylate Resins**

The self-curing unfilled resins have largely been replaced by the

new composites. They still hold a place in some practices. Failures have been largely manipulative, although the material inherently lacks some of the properties required of restoratives. The material is the easiest to finish of those considered.

Initial smoothing and shaping should be done with slowly rotating non-dentated fissure burs, moving lightly from acrylic to tooth. Overheating acrylic softens it. Light disk-ing and finishing with pumice and tin oxide produces a high degree of luster which is esthetically pleasing.

The water uptake and color instability of the acrylics, coupled with a high coefficient of expansion invites leakage and failure, although when used with care, many dentists have found success.

### **Composites or Filled Resins**

Of the virtues extolled in favor of the several relatively new composite materials, their poorest property clinically is the inability to finish and polish them readily.

Since the filled resins have a fairly high tensile strength, they may find favor in well-selected posterior areas, for restoring Class II's when necessary. The fact that these materials match the tooth color so well, make them especially difficult to finish, because the marginal outline is lost when the tooth is over-filled slightly. And gingivally, it cannot be seen. Radiopaque materials will serve a distinct advantage in post-operative trimming.

Initial finishing should be done where possible, with hand instruments, using gold knives and scalers proximally. Keeping the instruments angled obliquely so that a portion of the instrument is always supported by the tooth, as well as by the

restoration, will allow for trimming without the danger of over-cutting.

Because steel burs are quickly dulled by quartz-filled composites, it felt that the prudent use of either white porcelain stones or the previously mentioned 12-bladed carbide finishing burs,<sup>5</sup> (Figure 10), will

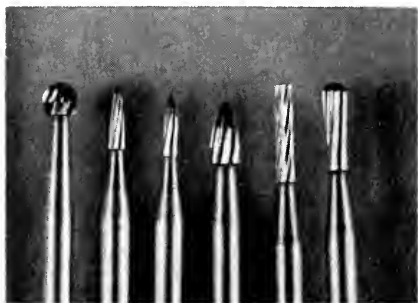


Figure 10. Specially shaped 12-bladed carbide finishing burs are designed for occlusal and proximal finishing.

provide the most rapid and smooth removal of excess. When run at high speed, it must be remembered that these instruments will cut enamel almost as quickly as the restorative material, and extreme caution must be taken. Reduced speeds will cut effectively and will produce clinically acceptable results.

Diamond stones produce a rougher finish than finishing burs, and will need further finishing with disks, or pumice and tin oxide. But the rougher surfaces of the finishing diamond instruments become smoother after brushing. As attrition continues clinically, it may be that the ultimate roughness will depend entirely upon the character of the filler.

Specially shaped needle shaped burs, (Figure 10) recently designed for proximal finishing are now available. Carbide burs do not leave the discoloration of steel residue.

Since it cannot be hoped that the surfaces of the composites will ultimately present more than a reasonably acceptable texture, and not polished ones, the patient needs to be instructed in good home care to maintain healthy gingival tissues. There is no evidence at this time that the texture of the composites will attract more plaque than other materials, but it is logical to presume that it may attach more **quickly** than to metallic restorations.

The matrix strip produces a high polished surface, but the gloss can be seen to disappear quickly after only a few hundred brushing strokes with commonly used dentifrices. Under the critical scrutiny of the profilometer, it is measurably rougher.

Investigations may prove one material to produce a better surface than another, because of the type filler that is used, but the fact remains that at best, the composite is made up of 70 to 80 per cent filler, supported by a softer resinous matrix, and as a restorative material, is not homogenous.

Since the composites have enjoyed a reasonable acceptance overall, and exhibit good physical properties, its imperfect polish can perhaps be temporarily conceded, until improved materials are developed.

## Conclusion

Any effort to finish the restoration is important in bringing out the best in any material. The techniques and the inherent properties of the materials used are highly important to appreciate and to understand. But, perhaps the most meaningful result is the establishing of an attitude and a discipline in behalf of

the health and welfare of the patient that is being served.

The satisfaction of being able to do something well, and fulfilling this ability, generates excellence and inspires confidence, which makes the effort worthwhile.

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# The Ankylosed Tooth

By Frank P. Stout, D.D.S.

The importance of early diagnosis of the ankylosed tooth and the detrimental effects of neglect have an obvious and profound relation within the practice of dentistry.

The decision on what, when and how to treat tooth ankylosis may not appear as acute as the pulpal exposure. However it exists as a genuine problem with which every dental practitioner must reckon.

The objective of this review is to familiarize the reader with the literature concerning clinical observations, occurrence, diagnosis, histology, etiology, problems of neglect, and the treatment of tooth ankylosis.

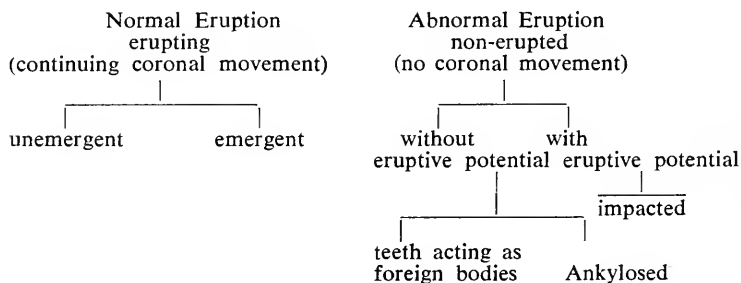
## Clinical Observations

Biederman<sup>1</sup> explains that tooth ankylosis is an aberration of tooth eruption. Any tooth in which coronal movement has been stopped is a "non-erupted" tooth. The latter should not be confused with an "unerupted tooth," which is one that has not emerged into the oral cavity but is still moving. The unerupted tooth is normal. The non-erupted tooth is abnormal. If the tooth is non-erupted because of some interposing tooth or tissue it is "im-

pacted." When eruptive potential has been destroyed and the problem is permanent, the "non-erupted" tooth belongs to one of two categories. Where the dental papilla has been destroyed, the remaining enamel shell is incapable of further eruption and become essentially a "benign foreign body." The other non-erupted category without eruptive potential is the "ankylosed tooth."

The term "submerged tooth" has been used interchangeably with the term "ankylosed tooth." Histologic and cephalometric studies<sup>2, 3, 4, 5</sup> have shown, however that the term submerged is in fact a misnomer. Ankylosed teeth do not grow down into or up into alveolar bone, rather they fail to continue to grow to the new level of occlusion during the growth and development of the remaining dentition. The alveolar structure supporting all the other teeth continues to grow and develop while the ankylosed tooth only appears to be "submerging."

A unique characteristic of ankylosis has been reported.<sup>1, 5, 6, 7</sup> Once ankylosed, no matter where located, the tooth is fixed in position. If the ankylosis occurs early, overgrowth of surrounding tissue may be ex-



treme, but once exposed, the tooth is never completely covered again. There will always be an epithelial tube connecting the occlusal surface of the ankylosed tooth with the oral cavity. The presence or absence of such a tube determines whether ankylosis took place before or after emergence.

Case reports have shown where in clinical evaluation a primary tooth appears to be totally unerupted; yet, upon X-Ray evaluation the same tooth has exhibited an amalgam restoration.

### Occurrence

The literature concerning the occurrence of tooth ankylosis reveals several documented facts.<sup>8, 9, 10, 11, 12</sup> Lower 2nd primary molars are the most frequently ankylosed tooth and either unilateral or bilateral conditions may exist. Although ankylosis can involve any tooth and can be seen at any age, it is most often observed during the primary or mixed dentition. Primary teeth become ankylosed more than ten times as often as permanent teeth. When the upper teeth are ankylosed, the lower antagonist are usually ankylosed also.

### Diagnosis

Four methods of diagnosing tooth ankylosis have been reported. One method is percussion. The ankylosed tooth will have a clear solid sound on percussion, giving the impression that the tooth is an integral part of and fused to the skull. The normal tooth on percussion will have a muffled, dull cushioned or full sound because of the cushioning effect of the periodontal membrane.<sup>3, 9, 13, 10</sup>

A second method of diagnosis is non-mobility. Absence of tooth mo-

bility even when the X-Ray shows advanced root resorption, should suggest ankylosis.<sup>3, 13, 10</sup>

A third method of diagnosis is the X-Ray. Vorkies<sup>3</sup> reported that ankylosed teeth may show certain areas of sclerotic osseous tissue, areas with a *moth eaten appearance* or an intact periodontal membrane, where normally an unbroken periodontal membrane resided. Herman,<sup>9</sup> Owens,<sup>13</sup> Kelsten,<sup>10</sup> all agree that the ankylosed tooth usually reveals a partial obliteration of the periodontal membrane with an apparent blending of the root with the adjacent bone.

Many investigators<sup>14, 15, 16</sup> disagree with the usefulness of the X-Ray. They maintain that the X-Ray is not sufficiently clear to diagnose tooth ankylosis. In 1964, Thornton, Myers and Zimmernan<sup>17</sup> performed a roentgenographic and histologic study on twenty-two ankylosed teeth and concluded that roentgenograms were of little value in detecting the early onset of ankylosis. They reported in 4 of the ankylosed teeth studied, areas of ankylosis existed in positions not usually discernible in X-Rays. In a similar histologic and roentgenographic study, Parker<sup>16</sup> revealed that in a number of the teeth that seemed ankylosed by X-Ray, there actually were repairs in which new bone was still separated from the dentition by a narrow periodontal membrane.

The fourth method of diagnosis is clinical observation. Any tooth which appears to be below the plane of occlusion should be checked for ankylosis, provided that no habit exists and providing that no tissue is preventing normal growth.<sup>9, 3, 13, 14</sup>

## Histology

Dental practitioners, through experience with replanted teeth, have come to realize that ankylosed teeth undergo resorption. Thornton<sup>17</sup> commented on this in 1964, in reporting that resorption of the ankylosed tooth and its subsequent repair with bone increased with the duration of ankylosis. He further stated that findings suggested that if the process of ankylosis were permitted to continue, a complete replacement of tooth by bone would occur. Biederman<sup>1</sup> has shown that once a tooth is ankylosed, the connective tissue derivatives (cementum, dentine, periodontal ligament and pulp) all tend ultimately to be replaced by bone. This substitution of more highly specialized connective tissue derivatives by bone is characteristic of tooth ankylosis.

Vorkies and McDonald<sup>3</sup> have reported histologic observations of ankylosed primary molars. They wrote that *osseous ankylosis* lies between dentin and bone and is carried on in close proximity with osteoclastic activity. In one area osteoclastic activity on old dentin is prevalent and a few microns away osteoblasts are laying down osteoid tissue which is hyperplastic and is not entirely like alveolar bone. They added that the picture appears to be one in which this double activity of resorption and osseous deposition seemingly bores through solid tooth structure leaving in its wake an "atypical bone."

## Etiology

The accepted etiology for ankylosed teeth was and still appears to be mechanical trauma. Herman<sup>9</sup> in 1964 suggested this when he re-

ported that ankylosis involved alternation in the periodontal membrane during the repair phase after injury to the root or adjacent tissues.

Many studies in replanted teeth after luxation have pointed out the connection of the vital periodontal membrane and ankylosis. In 1964, Knight and Gaus<sup>18</sup> conducted a study on replanted teeth in dogs and reported ankylosis in about one half of the replants. Ravin, J. J. and Helbo in 1966 studied replanted teeth in humans and showed that 16 of 28 teeth that were retained longer than 2 years underwent ankylosis and that 90 percent of the teeth replanted after 30 days showed ankylosis.

Efforts to disprove the *Traumatic Theory* have been reported. Parker, Frisbe, Harry<sup>16</sup> in 1964 produced ankylosis experimentally by immobilizing selected teeth with splints reflecting the investing tissue, mechanically injuring the roots and adjacent bone and grinding the teeth out of occlusion. In no instance where the teeth were operated and left in occlusion did any ankylosis occur.

In an attempt to produce experimental ankylosis, Rubin and Biederman<sup>19</sup> concluded that although tooth ankylosis can be induced by extraction and implantation, direct trauma short of such radical procedures have failed. They inferred that current evidence does not substantiate the traumatic theory concept.

Brauer<sup>20</sup> concluded that resorption is an intermittent process; periods of activity alternating with periods of rest. He remarked that during remission, the areas of resorption of the root are partly filled in by cementum and that ankylosis

may occur when repair is excessive and bone is laid down instead of new cementum.

### Problems of Neglected Ankylosis

Serious problems have been reported from neglected ankylosed teeth. The most severe of these is malocclusion.<sup>5, 21</sup> When eruption is halted in an ankylosed tooth, the adjacent teeth continue normal growth, this immediately results in a break in the continuity of contact points. The forward propelling forces cause the adjacent teeth to tip toward each other. As the inclined planes become more affected the size of the arch is reduced antero-posteriorly and laterally. This alters the shape of the arch and development of facial structure.

Specific dental problems also arise from neglected ankylosis. Vorkies<sup>3</sup> points out that, as the adjacent teeth or even the opposing teeth continue their eruption, normal proximal contact is lost. This offers a favorable situation for the caries process. Thus, not only are the permanent and remaining primary teeth endangered by caries but also because of the inclination of the permanent teeth, food impaction and consequent periodontal complications can be expected.

### Treatment

No explicit rules appear to be applicable in the treatment of tooth ankylosis.

It is felt by some investigators<sup>8, 9</sup> that all ankylosed teeth should be removed. In the event that they are not removed, a semi-annual check-up should be maintained to make certain that no irreversible changes occur. When an ankylosed primary

molar is removed, the bone overlying the crown of the unerupted succedaneous tooth must be removed, to the extent of the largest diameter of that tooth, otherwise eruption may be impeded.

Moyes<sup>22</sup> reports that treatment of ankylosed teeth must be oriented to prevent three possible occurrences: (1) loss of arch length (2) extrusion of teeth in the opposite arch and (3) interference with the eruption of succeeding permanent teeth. He feels the judicious use of space maintainers and regainers is advisable if the length of the arch is jeopardized. He reported that, should the opposing teeth begin to extrude, two courses of action are open. These are placement of a stainless steel crown form on the ankylosed tooth to restore its occlusal height until it must be extracted or removal of the ankylosed tooth and placement of a space maintainer which will occlude with the opposing teeth.

Higley<sup>20</sup> reported that unerupted teeth suspected to be ankylosed should be uncovered and space made for them if needed, thus giving them every opportunity to erupt into occlusion. Orthodontic tooth movement may also be attempted on the tooth in question, but he feels that if it is actually ankylosed it will *not be successful*.

A more realistic approach to the treatment of ankylosed teeth is to treat each situation independently. For instance, if ankylosed primary molars, are diagnosed in the early stages, succedaneous premolars may not be ready to erupt; the proximal contact may still be maintained; the opposing teeth may not be extruding and the tissue crown level may be sufficient to allow proper clear-

ing and tissue stimulation. Indeed with careful supervision such ankylosed teeth often serve as excellent space maintainers.

The combination ankylosed primary molar and congenitally missing premolar presents another situation which must be handled on an individual basis. Several questions have to be answered by the practitioner if a successful treatment result is to be gained. Is the ankylosis on-set early or late (slightly or severely submerged)? Is the permanent six year molar erupting, fully erupted or unerupted? How many premolars are missing, 4, 3, 2, or 1. Does the patient present a class I, II, III type dental malocclusion? Is there an anterior, posterior basal arch skeletal discrepancy (ANB); if so how severe? How acceptable is the soft tissue profile? Is the profile concave, convex or straight. Are the lips markedly recessive, if so then is the patient male or female? Is either arch crowded? Is the bite deep?

All of these question are inextricable and intertwined. The answers must be known and calculated or what might be thought of as simple treatment plan, could turn into an orthodontic nightmare with the patient's face (profile) as proof.

A safe rule concerning ankylosed teeth might be, as soon as the diagnosis has been confirmed, obtain an orthodontic consultation.

### Summary

A review of the current literature concerning tooth ankylosis has been presented. Areas of emphasis were

Clinical Observations, Occurrence, Diagnosis, Histology, Etiology, Problems of Neglected Ankylosis and Treatment.

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## **Plaque-Reducing Chewing Gum**

An experimental chewing gum containing a 1 per cent concentration of the digestant Viokase has been found to produce significant reduction of dental plaque when compared with a placebo gum, according to a study by Drs. Don L. Allen and Richard M. Courtney, in an article published in the current issue of *Journal of Periodontology* Vol. 43, No. 3 (March, 1972).

The digestant Viokase contains amylolytic and proteolytic enzymes which have been demonstrated in earlier studies to be effective in calculus reduction. Recent data reconfirm, both at the experimental and epidemiological levels, the strong relationship between dental plaque and periodontal disease. However, earlier investigations were not designed to clinically measure the amount of plaque reduction in human subjects through use of enzyme-containing digestants.

The Allen-Courtney test was a double-blind, cross-over experiment to determine the plaque removal potential of a Viokase-containing chewing gum, and was conducted on a test population of 91 persons. The test was supported by a grant from Philip Morris Inc. and was conducted at the Dental Research Center, University of North Carolina School of Dentistry, Chapel Hill, North Carolina.

The persons being tested were divided in two groups of 45 and 46. The group of 45 persons were given the experimental Viokase-containing

gum to chew for three weeks, no gum at all for six weeks (in order to eliminate any residual enzymatic activity), then a placebo gum with no added enzyme for three weeks.

The second group of 46 persons was given the placebo gum for the first three weeks, followed by a six-week period of no gum, then three weeks of using the Viokase gum.

All the sugar-free gums were provided by the manufacturer in five-stick packs with ten codes, but without labels. Five codes were provided for the Viokase gum and five for the placebo.

Persons taking the test were not given a dental prophylaxis before or during the study.

Each test person was first given an oral examination and his plaque index was determined (using the Simplified Oral Hygiene Index ranging from 1 to 14) through observed use of disclosing wafers. Each test person was then given oral and written instructions in the use of the chewing gum and was provided with a one-week supply. Test persons were told to chew five sticks of gum per day, evenly spaced throughout the waking hours. Subjects were evaluated at the end of one and three weeks.

One of the two investigators carrying out the study evaluated dental plaque status, and the other evaluated whether or not the Viokase chewing gum produced any irritability or untoward symptoms.

Tabulations of measurements

during and at the conclusion of the study showed that the chewing gum containing Viokase produced a significantly greater plaque reduction than the placebo gum at the 5 per cent level of confidence. When a statistical analysis was performed on data of these subjects with an initial plaque score of six or higher, a somewhat greater level of confidence was shown at the 2 per cent level.

Although no changes were noted in soft tissue examination that could be directly attributed to the Viokase-containing chewing gum, approximately 55 per cent of the subjects responded unfavorably to the enzyme-containing gum. The most common complaints were mouth irritation and an undesirable flavor. Irritation in the soft tissues was most frequently described as a burning sensation to the tongue while the

Viokase-containing gum was being chewed, but it was noted that this sensation became less evident as use of the gum continued.

The clinicians conducting the study concluded that further long-term studies using multiple enzymes for plaque control need to be undertaken, and that a vehicle is needed which is more pleasant and less irritating to the subjects, before this approach to plaque control can gain public acceptance.

Dr. Allen is Professor of Periodontology, University of Florida College of Dentistry, and Dr. Courtney is Associate Professor of Oral Pathology, University of Michigan School of Dentistry.

THE AMERICAN ACADEMY  
OF PERIODONTOLOGY  
211 EAST CHICAGO AVE.,  
CHICAGO, ILLINOIS

# North Carolina Dental Assistants Association



Miss Aileen B. Croom of Wilmington, presided over the Twenty-Second Annual Session of the North Carolina Dental Assistants Association at Sheraton Motor Inn in Southern Pines, May 14-16. Wilma Wilson of Lexington was program chairman for the meeting.

Speakers for the three day meeting included: Mrs. Iva Coulter, A.D.A.A. President; Mrs. Helen Meridith, Trustee A.D.A.A. Fourth District; Dr. William P. Hinson, Jr., of High Point; Dr. Glen Hunt of Greensboro; and Dr. George Mayo, III, of Goldsboro.

The Powers and Anderson Cooperation Award was presented to the Charlotte Dental Assistants Society. The Dr. James M. Holland Loyal Assistant Award was presented to Callie Love of Charlotte. She has been with Drs. Morris and Morris for 25 years.

The Dr. William H. Oliver Achievement Award for most outstanding work was presented to Aileen Croom, the Best Newsletter Article Award went to Lurlene Medford, and Cape Fear Dental Assistants Society won the G. P. Bryant Membership Award.

Alamance-Caswell Dental Assistants Society won The Charlotte Laboratory Attendance Award, and The Charlotte Dental Assistants Society, The Harry Lemmons Membership Award. The Dr. Paul B. Morefield Award for the best educational programs was presented to Durham-Orange Dental Assistants Society.

Officers installed for 1972-73 were: Wilma Wilson, Lexington, President; Linda Heffinger, Eden, President-Elect; Betty Scott, Goldsboro, Vice President; Cheryl Kearney, Snow Hill, Secretary; Lurlene Medford, Asheville, Assistant Secretary; and Barbara Talbert, Chapel Hill, Treasurer.

# Items of Interest

## ADA Cites Inequities In Phase II Controls

Inequities in the controls placed on dentists under Phase II of the Economic Stabilization Program are under renewed protest by the ADA.

The inequities of the present restrictions on dental fees were pointed out in a letter to Treasury Secretary John B. Connally, who also is chairman of the Cost of Living Council. No other class of businesses or professions is subject to as harsh a restriction on prices or fees as are the non-institutional health care providers, Dr. Laughlin said in a letter to Mr. Connally. He asked that practicing dentists be exempted from the price controls in a manner similar to other small businesses.

## ADA Protests 'Misleading' Report on Dental Costs

ADA has directed a strong protest to the president of the CBS News Division of the Columbia Broadcasting System concerning a "news" report comparing dental costs in the United States and Germany. In a letter to Mr. Richard S. Salant, Mr. Peter C. Goulding, ADA director of communications, labels statements made in the report as "truly incredible, misleading and deceptive." The report was brought to the attention of the Association by many members who heard it on CBS radio and television.

## AADS Installs New President

Mr. Reginald H. Sullens of Oklahoma City, Okla., associate dean for

administrative affairs of the University of Oklahoma dental school, was installed as president of the American Association of Dental Schools at its recent annual session held in Las Vegas, Nev. He succeeds Dr. John J. Salley of Baltimore, dean of the University of Maryland dental school.

Dr. Charles L. Howell of Philadelphia, dean of Temple University dental school, was chosen president-elect.

Miss Alberta Beat of Chapel Hill, N. C., University of North Carolina dental school, was named vice president for auxiliaries.

## National Health Insurance

Congress will probably not adopt any national health insurance proposal this year, a U. S. congressman predicted last week. Rep. Al Ullman (D.-Ore.), ranking majority member of the House Ways and Means Committee, said it will be a "long, tedious task" as Congress studies all proposals and finally takes action.

He also commented on a recent regulation under Medicaid requiring, among other benefits, dental care for children. He pointed out that the Senate Finance Committee in an amendment to H.R. 1 (Social Security Amendments of 1972) had proposed to eliminate dental care and several other benefits from the new children's plan. However, Rep. Ullman continued, he expects the House Ways and Means Committee to resist any changes in the children's plan if such an amendment

to H.R. 1 is referred to a conference committee of both houses of Congress.

## **General Practitioners Need Unified Voice**

The need for a unified voice for the general practitioner is greater than ever, Dr. Erik D. Olsen, Executive Director of the Academy of General Dentistry, told California dentists May 10, as he outlined plans for a more comprehensive program by the Academy to fulfill this need.

Speaking before the May meeting of the Southern California Academy of General Dentistry in the Huntington Sheraton Hotel, Pasadena, Dr. Olsen said:

"The Academy of General Dentistry has recognized that the time is now for the general practitioner to remind the profession that he is in the forefront, he is in the majority, and while relatively unrecognized, he is responsible for the day-to-day delivery of dental care.

"As dental care programs and health legislative proposals continue to multiply, the need for a unified voice of the general practitioner continues to mount. The Academy of General Dentistry has taken action to speak as one for the 85 per cent of the dental profession that is in the forefront of the actual delivery of dental health care."

Dr. Olsen said the Academy will stand firm on its position that the right of the general practitioner to practice all phases of dentistry must be preserved.

"We have notified the American Dental Association," he said, "that we expect enforcement of the current ADA policy which emphasizes

the patient's right to freedom of choice in the selection of his dentist and that licensed dentists be permitted to perform all operations and provide all services."

## **ASDC to Meet in San Francisco**

The rapidly growing interest among dentists who treat children in their practices in the early detection of malocclusion and the possible prevention of severe malocclusion will be the subject of intensive discussion at the 1972 Annual Meeting of the American Society of Dentistry for Children (ASDC) at the St. Francis Hotel in San Francisco, California, October 27-29.

Dr. Charles A. Sweet, Jr. of Oakland, California is general chairman of the ASDC meeting in San Francisco. All dentists are invited to attend.

## **Prosthodontists to Meet At Vegas**

Las Vegas becomes the prosthodontic capital of the world October 26, 27, 28 when 73 essayists of world-renown will appear before the First International Prosthodontic Congress.

Five concurrent sessions have been scheduled for each day. The Congress meets in the Las Vegas Hilton Hotel. It is sponsored by the Federation of Prosthodontic Organizations with the American Prosthodontic Society as host.

Dr. Enrique Echeverri, Head, Dept. of Oral Rehabilitation at Javeriana University School of Dentistry, Bogota, Colombia.

## **25,000 Dentists Expected**

More than 25,000 dentists, their wives and guests are expected to attend the 113th annual session of the American Dental Association scheduled October 29 through November 2 in San Francisco.

Prevention will be the overriding theme of the entire scientific program. Preventive techniques will be highlighted by all sections of the scientific session which will feature more than 1,000 essays, scientific session lectures, exhibits, table clinics and motion pictures.

For the first time limited attendance seminars will be conducted during the scientific program. Each seminar will be limited to 50 persons who will have purchased tickets at \$5 in advance. Proceeds will benefit the American Dental Association Health Foundation.

## **California's Two "State" Dental Associations Unify**

Unification of the California Dental Association and the Southern California Dental Association was approved Saturday, June 3, as the House of Delegates of the two Associations met jointly in San Francisco and each adopted the final unification agreement by an overwhelming majority.

The "new" California Dental Association, consisting of over 11,000 dentists, will begin operations in May, 1973, immediately following the conclusion of the two existing Associations' annual scientific sessions, and will be headquartered in the Southern California Dental Association's present facilities in the Airport Marina Hotel Complex in Los Angeles.

## **20 Dentists Assigned by Health Service Corps**

Twenty dentists were among 288 health professionals to be assigned in May to 122 communities throughout the country in the first major placements made by the National Health Service Corps.

The new federal agency was created to place health personnel in areas short of health services. The dentists along with physicians, nurses and other health personnel will start work in July to provide health services to residents in low-income and rural areas.

The dentists assigned will only go to areas that have received certification of need from the local and state dental societies.

## **New Leaflet on Fluoridation**

"Fluoridation . . . Nature's Way to Prevent Tooth Decay" is the latest in a series of leaflets on fluoridation to be released by the Division of Dental Health, National Institutes of Health, DHEW. It explains the terms "natural" fluoridation and "adjusted" fluoridation, emphasizing that the source of the fluoride ion is immaterial to its absorption and use in the body. Adjusting the fluoride content of the water is man's way to duplicate nature's way to better dental health. Single copies are available from the Division of Dental Health, Room 302, Federal Building, 9000 Rockville Pike, Bethesda, Maryland 20014, or it may be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. Price is five cents each, \$2.25 per 100 copies.

# First District Dental Society



**Fred N. Ogden, II**  
**President**

## Fellowship - Fun - Frolic

ONCE AGAIN, the approach of Fall brings us together for the 1972 First District Dental Society meeting. Last year set the stage for a new meeting place and it was so well received that the District is meeting again at The Green Park Hotel, Blowing Rock, this year, September 28, 29 and October 1.

Having the hotel all to ourselves unified everyone and it was like one big happy family. At sixteen dollars for room and board per person who could be unhappy?

Entertainment is excellent for this meeting. We plan to get things started Friday evening with a social hour, followed with dinner and a dance.

This year our guest clinician Dr. Reuben Groom of Jacksonville, Florida will enlighten us for two half days.

Sunday lunch will close our meeting with the drawing of door prizes and the turning of the gavel over to our in-coming president, Dr. "Puff" Hord.

Let me welcome all dentists, wives, auxiliary and guests to the First District meeting this fall.

## **FIRST DISTRICT**

# **Program**

**GREEN PARK HOTEL  
BLOWING ROCK, NORTH CAROLINA  
SEPTEMBER 29-OCTOBER 1, 1972**

### **Friday, September 29**

<b>12:00</b>	Golf Tournament—Blowing Rock Country Club
<b>6:00-7:30</b>	Cocktail Party
<b>7:30</b>	Dinner
<b>9:00</b>	Dance

### **Saturday, September 30**

<b>9:00</b>	Table Clinics
<b>2:00</b>	Clinician—Dr. Reuben Groom
<b>6:00-7:00</b>	Cocktail Party and Reception for State Officers
<b>7:00</b>	Dinner
<b>8:30</b>	Annual Business Meeting

### **Sunday, October 1**

<b>9:00</b>	Clinician—Dr. Reuben Groom
<b>1:00</b>	Luncheon with Auxiliary Installation of New Officers

## **Table Clinics**

### **Saturday, September 30**

**9:00 a.m.**

- 1. Use of Panoramic Radiographs in Diagnosis**, John Bottoms, Waynesville.
- 2. One Appointment Endodontic Therapy for Anterior Teeth**, Benjamin T. Ellis, Grover.
- 3. Restoring Abraded Teeth**, Robert Owen, Asheville.
- 4. Effective Appointment Book Control**, Robert Garren, Asheville.
- 5. Space Maintenance and Intraceptive Orthodontics**, James Elliott, Asheville.
- 6. Relative Analgesia in General Practice**, Don Draper, Hendersonville.
- 7. Crown Restoration under Existing Partial Denture**, Richard Bowling, Hendersonville.

## **FIRST DISTRICT**

# **Clinician**

**Reuben P. Groom**  
**Jacksonville, Florida**



**Saturday, September 30**

**2:00 p.m.**

**Sunday, October 1**

**9:00 a.m.**

Dr. Reuben P. Groom is a native Floridian, a graduate of the University of Florida and Emory University College of Dentistry. He served three years in the U. S. Army Dental Corps and has practiced in Jacksonville, Florida since 1946. He has served as President of the Jacksonville Dental Society, the Northeast District Dental Society, the Florida Dental Association and the Academy of Dentistry of Jacksonville, Inc. He is presently serving as Secretary of the Florida State Board of Dentistry. He initiated the Kiwanis Charity Dental Clinic in 1952 and single-handedly initiated the plan for scholarships whereby members of the Florida Dental Association voted unanimously to raise their dues to make \$25,000.00 per year available to dental students. He has worked tirelessly to up-grade the status of dental assistants.

Dr. Groom's presentation will be concerned with Practice Management. Special emphasis will be given to office appearance and the dentist's personal health problems and practice control through appointment book control coupled with the proper use of auxiliary personnel.

# Second District Dental Society



**William H. Price**  
**President**

## Eighth Tar Heel Dental Seminar

**W**ELCOME to the Eighth Tar Heel Dental Seminar on September 24-26, 1972. This year's program promises to be exciting and profitable not only to the dentist but to their wives and staff as well. As techniques and theories have developed at a rapid rate, a most important aspect has lagged behind—that of improving our own professional leadership.

Mr. Allan Hurst, a recognized authority in Patient Motivation and Communication has been secured. During the most recent Practice Management Seminar in Chicago, he spoke for two days to "standing room only" audiences. His presentation will begin Sunday afternoon and continue through Monday.

Fabulous prizes are in store for a Monte Carlo Club night on Monday evening. This will be preceded by a cocktail-buffet. Losing will be practically an impossibility.

Outstanding table clinics have been arranged for Tuesday morning from our own members. Two excellent projected clinics will follow on Tuesday morning. The presentations by Dr. Ted Oldenburg from UNC School of Dentistry and Dr. Stuart Fountain of Greensboro will be well worth your attendance.

The overall program is designed for the entire staff—both social and scientific. A hearty welcome to all North Carolina dentists and their staffs is extended to all lectures. Social functions are open to our hygienists and assistants.

Pre-registration is advised at the Holiday Inn—North in Charlotte. The motel will hold our block of rooms only until two weeks before the meeting. After that, it's first come—first served.

## SECOND DISTRICT

# **Program**

### **HOLIDAY INN—NORTH CHARLOTTE, NORTH CAROLINA SEPTEMBER 24-26, 1972**

#### Sunday, September 24

- 10:00** Executive Committee Meeting in President's Suite  
**12:30- 5:00** Registration and Ticket Sales  
**2:00- 4:45** Mr. Allan Hurst  
**5:00- 6:00** First General Session  
Election of New Members  
Election of New Officers  
Necrology Service (Stewart Peery)  
Reports of Secretary-Treasurers  
Committee Reports  
Appointment of Committee on President's Report  
**6:30** Social Hour  
**8:00** Banquet  
Guest Introductions  
Installation of New Members, President of NCDS  
Installation of New Officers

#### Monday, September 25

- 8:00** New Members, Breakfast  
Frank Daniel, Presiding  
**8:30-12:30** Registration and Ticket Sales  
**9:00-12:00** Mr. Allan Hurst  
**12:30- 2:00** Business Luncheon  
Reports:  
1. Joseph Johnson, President, NCDS  
2. Dean of UNC, James Bawden  
3. Executive Secretary NCDS, Andrew Cunningham  
4. Representative of Industrial Commission, William Stephenson  
President's Message  
**2:00- 5:00** Mr. Allan Hurst  
**6:00** Social Hour  
**7:00** Buffet Dinner  
**8:00** Monte Carlo Casino  
**10:30** Auction

#### Tuesday, September 26

- 8:30-10:30** Table Clinics  
**10:30** Projected Clinics  
**12:00** Final Business Session

## **Clinician**



**Allan Hurst**  
**Kansas City, Missouri**

Allan Hurst is a principal member of Lawrence-Leiter and Company, Kansas City, Missouri; the largest consulting firm in general management between Chicago and the West Coast.

Mr. Hurst is currently engaged by several major universities and numerous trade associations and professional societies to conduct his stirring, stimulating and always entertaining seminars in personal leadership, communications and development.

He has a unique ability to direct his message to the particular group at hand and to impart "real life" viewpoints to his presentations.

**Sunday, September 24**

**2:00 p.m.**

**Monday, September 25**

**9:00 a.m. and 2:00 p.m.**

### **IMPROVING PROFESSIONAL LEADERSHIP IN PATIENT MOTIVATION AND COMMUNICATION**

1. Personal Relations in Professional Practice
2. Patient Motivation: Accepting Dental Needs
3. Predicting Patient Behavior
4. Building Positive Communications
5. Feedback: The Key to Practice Development
6. Case Presentation: The Psychology of Acceptance
7. Programming the Practice Toward Success

## SECOND DISTRICT

### Table Clinics

**Tuesday, September 26**

**8:30 a.m.**

1. **Occlusion—Equilibration**, Dr. Guy E. Haddix, Statesville.
2. **Use of Inhalant Analgesia in General Dentistry**, Dr. Harold Twisdale Charlotte.
3. **How to Control Anxieties in the Dental Chair**, Dr. D. C. Evans, Charlotte.
4. **I. V. Analgesia**, Dr. W. Carter Lofton, Charlotte.
5. **Fixed—Removable Partial**, Dr. Lawrence P. Reed, Charlotte; and Dr. David Rynearson, Candler.
6. **The Composites—Their Placement and Finish**, Dr. Fred J. Smith, Winston-Salem.
7. **To be Announced**, Central Piedmont Community College Dental Assistants, Charlotte.
8. **To be Announced**, Central Piedmont Community College Dental Assistants, Charlotte.

### Projected Clinics

**Tuesday, September 26**

**10:30 a.m.**

1. **The Current Status of Pit and Fissure Sealants**, Theodore Oldenburg, Professor and Chairman, Department of Pedodontics, Chapel Hill. There is much research and controversy taking place regarding the use of pit and fissure sealants in dentistry. A series of slides illustrating the use of sealants presently on the market will be presented with a clinical evaluation of each. Recent research findings pertaining to the effectiveness of the pit and fissure sealants in controlling pit and fissure caries will also be discussed.
2. **Apical Closure Subsequent to Periapical Pathosis**, Stuart Fountain, Greensboro. It has previously been believed that apexification was not possible following chronic periapical disease. A discussion will cover the outstanding biological potential of the incompletely developed apex.

# Third District Dental Society



**Leonard R. Cashion**  
**President**

## Continued Education and Fun

**T**HE THIRD DISTRICT DENTAL SOCIETY will meet at the Four Seasons Holiday Inn in Greensboro, October 7-9. Your hosts are the Guilford County Dental Society and the High Point Dental Society. We extend an invitation to the North Carolina Dental Society, their wives and auxiliaries to attend.

Dr. Charles Horton has agreed to organize and moderate an open forum covering some of the issues in organized dentistry today. We think you will want to attend and participate in this forum. Following the forum, we will have a social hour and a Monte Carlo Nite. Don't miss bidding for the prizes.

We will not have table clinics or projected clinics this year, but we will have a continuing education program, second to none, presented by the faculty of one of the leading dental schools in the United States—The University of North Carolina. If you are interested in what's new in ideas, materials, or techniques, you will make an effort to hear what these men have to offer.

Dr. Charles W. Jarvis has accepted our invitation to speak to us October 8 and 9. Dr. Jarvis is a San Marcos, Texas, dentist who now extracts more laughs than he does teeth. His first session of two hours will deal with public and human relations and the sub-topic will be "One and One-Half Doctors." He will discuss the factors of success dealing particularly with our number one problem, how we get along with our patients and our fellow man—not to mention a wife! The second session will deal with the factors of success and happiness in dentistry.

Your auxiliary has planned an interesting tour of Old Salem and a luncheon at the Old Salem Tavern. We hope your wife will attend.

Mark off your appointment book now and plan to be with us at the Third District Meeting.

## THIRD DISTRICT

# Program

HOLIDAY INN FOUR SEASONS  
GREENSBORO  
OCTOBER 7-9, 1972

### Saturday, October 7

- 3:00- 6:00 Registration  
3:00- 5:00 Forum on Issues in Dentistry Today  
Moderator: C. W. Horton  
6:00- 7:00 Social Hour  
7:00- 8:00 Dinner  
8:00 Monte Carlo Nite

### Sunday, October 8

- 9:00-12:00 Presentation by Faculty  
Members UNC School of Dentistry  
8:00-12:00 Golf and Tennis  
11:00- 5:00 Registration  
11:00-12:00 Prospective New Member Orientation  
1:00- 3:00 Lunch (Open)  
3:00- 5:00 Dr. Charles Jarvis  
5:00- 6:00 First General Session  
7:00- 8:00 Social Hour  
8:00 Dinner

### Monday, October 9

- 9:00 Registration  
9:00-12:00 Dr. Charles Jarvis  
12:00- 1:30 New Members Luncheon  
1:30- 4:30 Presentation by Faculty  
Members UNC School of Dentistry  
4:30 Final General Session

## **Clinician**

**Charles Jarvis**  
**San Marcos, Texas**



Dr. Jarvis has practiced general dentistry in San Marcos, Texas since 1953. He averages 140 speeches a year throughout the United States.

**Sunday, October 8**

**3:00 p.m.**

**Monday, October 9**

**9:00 a.m.**

### **LIFE AS A DENTIST CAN BE FILLING**

Philosophy of practice—the happy approach to life—this is what's needed in dentistry today. Just why did you and I get into dentistry in the first place? If we are unhappy, we better go back and examine our motives for being in this profession. These items and many more will be examined and discussed. The two sessions of two hours each will be humorous, but with a message. This is the style of Dr. Jarvis and it has been highly successful even when dealing with a most important message.

## **Continued Education**

**Sunday, October 8**

**9:00-12:00 p.m.**

This year we will not have any table or projected clinics, as we have had in the past, but we will have a continuing education program. One faculty member from each department of the University of North Carolina School of Dentistry will present a program. New ideas, new and old materials and new techniques will be presented from each of the ten departments. You can not afford to miss the new format in continued education.

# Fourth District Dental Society



**James H. Edwards**  
**President**

## Friday Is the Day

**G**ET OUT YOUR CALENDAR and mark the date, Friday, October 13 as the beginning of the annual meeting of the Fourth District Dental Society. Again this year the meeting will be held in Raleigh and the location will be the Velvet Cloak Inn. Those of you who are familiar with this facility will know of its luxury and convenience.

Our program chairman, Dr. Frederick Hasty, was most fortunate in securing Dr. H. Paul Jacobi as our clinician. Dr. Jacobi will concentrate the new concepts in practice management, and those who have heard him know we have a treat in store. It would be advantageous for all dentists to have their office personnel with them for this address on Friday. Dr. Jacobi will begin promptly at 9:15.

With Dr. Hal Cockerham heading our entertainment committee, we know that the name of the game is fun. Poolside cocktail parties and the annual banquet will be included in the fare.

Saturday brings table clinics and our chairman, Dr. John Povlich, reports that we have an excellent variety that will be of interest to everyone.

Dr. Jerry Wood, sports committee chairman, has made arrangements for our golf tournament on Saturday. Bring your clubs and join us. A tennis tournament for the ladies is planned.

As always, we extend a very cordial invitation to the ladies. Raleigh is going all out for them with the Friday 13th sales.

We extend a cordial invitation to you to join us at the Velvet Cloak in Raleigh on October 13th and 14th. Who can tell what might happen when the thirteenth falls on Friday. We assure you it will be one to remember.

## **FOURTH DISTRICT**

# **Program**

**VELVET CLOAK INN, RALEIGH  
OCTOBER 13-14, 1972**

### **Friday, October 13**

- 8:15- 9:15** Registration, Main Lobby  
**9:15** Dr. H. Paul Jacobi, Clinician  
**10:45** Coffee Break  
**11:00** Dr. H. Paul Jacobi  
**12:30** Luncheon  
**2:00** Dr. H. Paul Jacobi  
**3:30** Coffee Break  
**3:45** Dr. H. Paul Jacobi  
**6:30** Poolside Social Hour and Buffet  
**8:30** First General Session

### **Saturday, October 14**

- 8:30- 9:30** Registration, Main Lobby  
**9:30-10:30** Table Clinics  
**10:30** Second General Session  
**1:00- 4:00** Golf Tournament  
**6:30- 7:30** Cocktail Hour  
**7:30- 9:00** Awards Banquet  
**9:00-12:00** Casino Party  
Dancing to live music

## **Clinician**

**H. Paul Jacobi**  
**Neenah, Wisconsin**



Dr. Jacobi is a 1950 graduate of Marquette University. He has lectured on practice management extensively throughout the United States and in many foreign countries.

**Friday, October 13**

**11:00 a.m. and 2:00 p.m.**

### **NEW FRONTIERS IN PRACTICE MANAGEMENT**

In this presentation Dr. Jacobi will concentrate on the practical and new concepts in Practice Management. He will present a real approach to building, managing, and maintaining a successful dental practice.

## **Table Clinics**

**Saturday, October 14**

**9:30-10:30 a.m.**

- 1. Bone Marrow Transplant for Alveolar Bone Regeneration, Dr. Reynold Carrevalle, Fayetteville**
- 2. Trouble Shooting Complete Dentures, Dr. Jack Sowter, Raleigh**
- 3. Phosphoric Acid Etching Techniques, Dr. Walter Parrish, Raleigh**
- 4. Skin Graft: Oral Application for Pre-Prosthetic Surgery, Dr. F. D. Bell, Dr. Benny Martin, Dr. R. D. Coffey, Jr., Raleigh**
- 5. Occlusion and Equilibration, Dr. Guy Haddix, Statesville**
- 6. Teaching Children Plague Control, Mrs. Kathy Pressly, Raleigh**
- 7. The Pedodontic Patient, Dr. E. Harvie Hill, Raleigh**

# Fifth District Dental Society



**James A. Privette**  
**President**

## New Site—Provocative Program

**T**HE FIFTH DISTRICT DENTAL SOCIETY is pleased that our growth in membership has necessitated a move to larger convention facilities. The annual meeting will be held at the Timme Plaza in the port city of Wilmington, September 14-16.

Our move was considered with great deliberation but the Timme Plaza offers so many advantages for a convention. It should be most enjoyable.

The Entertainment should be superb this year. Your arrangement committee has planned a "Hawaiian Luau" for Friday evening on the patio. Everyone should plan to bring appropriate dress. A delightful, fun-filled evening is expected. A dance will follow the "banquet."

We also feel another highlight of this meeting will be the Open Forum breakfast to be held Friday morning. The prime objective is to provide a source of information for all members as to the current activities and changes in dentistry that are taking place today on a state and national level. Representatives from a number of organizations will be present to answer questions from the general membership. We want you to be informed, so plan to be present.

Your Program Committee has secured an outstanding clinician, Dr. Frank Goodwin. His talk will be not only informative but very interesting. Let's make this the most successful meeting ever.

## **FIFTH DISTRICT**

# **Program**

**TIMME PLAZA MOTOR INN, WILMINGTON  
SEPTEMBER 14-16, 1972**

### **Thursday, September 14**

**4:00** Executive Committee Meeting  
**6:00- 9:00** Registration  
**9:00** General Session

### **Friday, September 15**

**7:30- 9:00** Open Forum Breakfast  
**8:00-10:00** Registration  
**9:00-11:30** Dr. Frank Goodwin  
**10:30** Coffee  
**12:00- 1:00** Luncheon  
**1:30- 4:30** Dr. Frank Goodwin  
**6:00- 7:00** Social Hour  
**7:00- 9:00** Luau  
**9:00** Dance

### **Saturday, September 16**

**8:30** New Members Breakfast  
**9:30-11:00** Projected Table Clinics  
**11:00-12:00** Final General Session  
**12:00** Executive Committee Meeting

## **FIFTH DISTRICT**

# **Projected Clinics**

**Saturday, September 16**

**9:30 a.m.-11:00 a.m.**

- 1. The Bimler Applicance**, T. C. Hesmer, Wilson.
- 2. One Appointment Root Canal Treatment**, Fred H. Miller, New Bern.
- 3. Vitamin Therapy**, C. B. Smith, Wilmington.
- 4. Intravenous Premedication**, Jay Collie, Greenville.

## **Clinician**



**Frank Goodwin  
Gainesville, Florida**

Dr. Goodwin joined the faculty of the University of Florida in 1947 where he is currently professor of marketing, teaching courses in sales and sales management. In the past 18 years he has talked to audiences of over one and a quarter million people in 47 states and has contributed over 120 articles to trade journals.

He is a past president of the Gainesville (Florida) Exchange Club and is a member of numerous fraternal and business organizations in the fields of business, economics, sales and advertising.

**Friday, September 15**

**9:00 a.m. and 1:30 p.m.**

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250.00	124.50	142.00	204.50	284.50	352.00	
200.00	100.50	114.50	164.50	228.50	282.50	
150.00	76.50	87.00	124.50	172.50	213.00	

<div>Plan L-65</div>		Maximum Accident Benefits Lifetime	Maximum Sickness Benefits To Age 65			
Weekly Benefits		SEMI-ANNUAL RATES				
	Under 30	30-39	40-49	50-59	60-69	
\$300.00	\$184.50	\$211.50	\$289.50	\$388.50	\$421.50	
250.00	154.50	177.00	242.00	324.50	352.00	
200.00	124.50	142.50	194.50	260.50	282.50	
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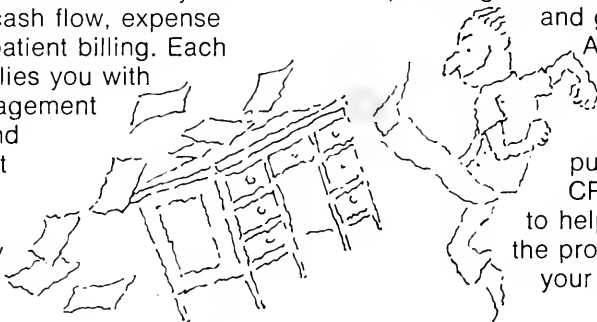
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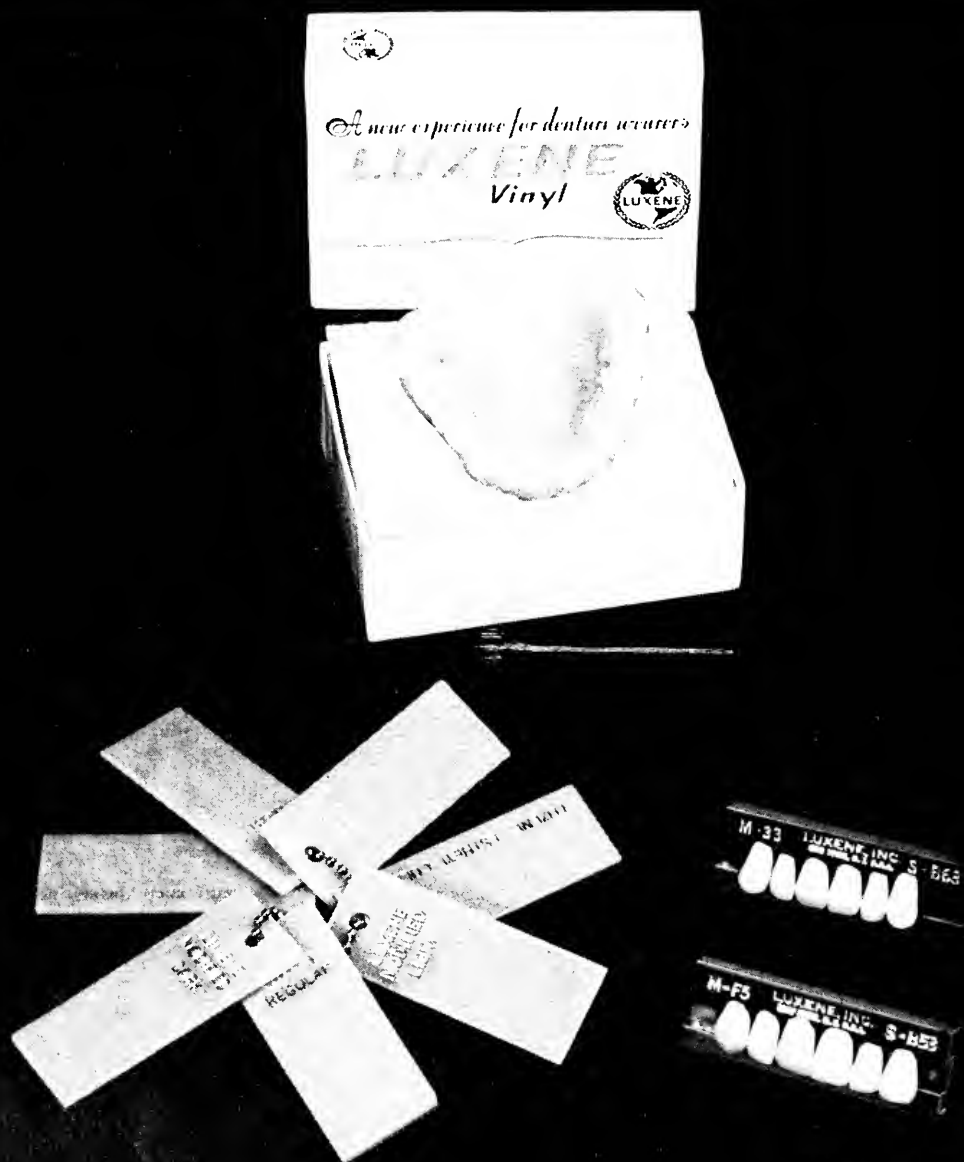
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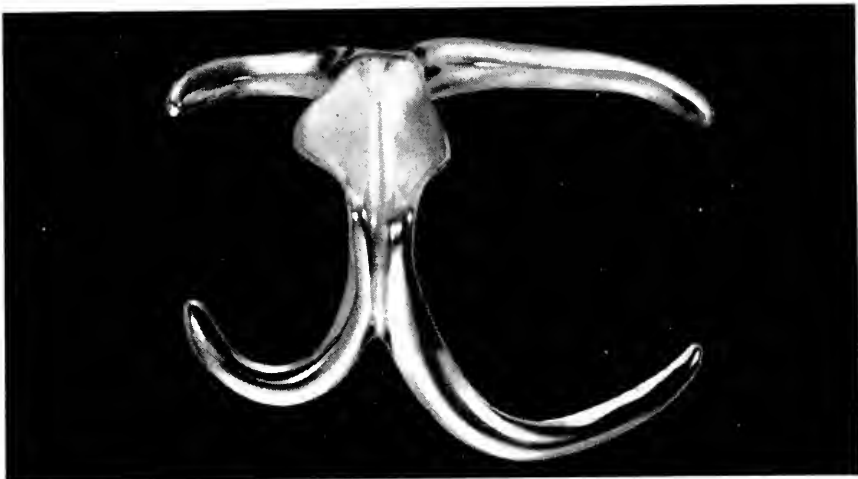
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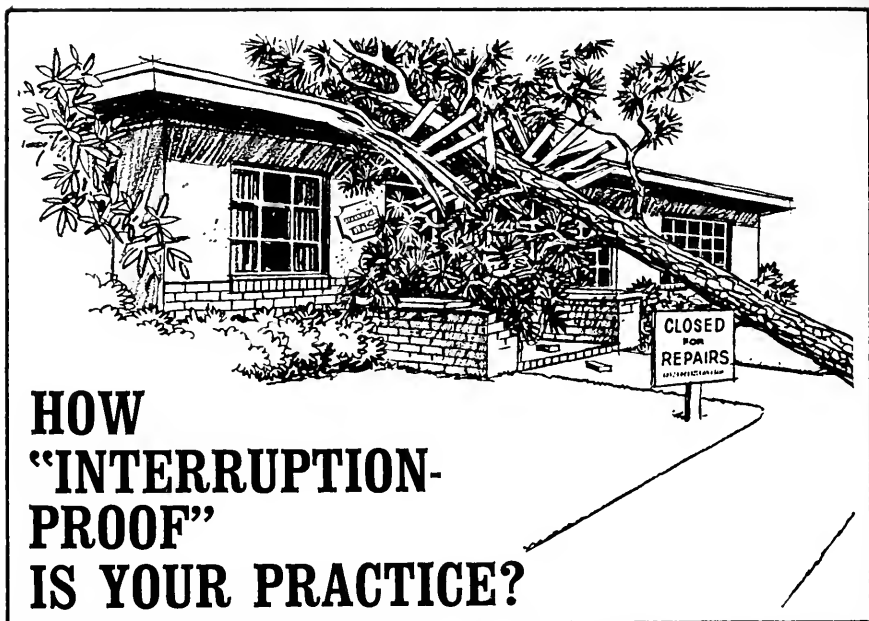
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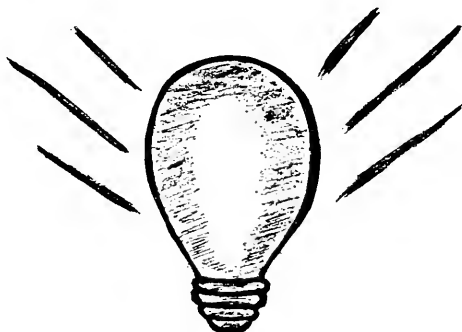
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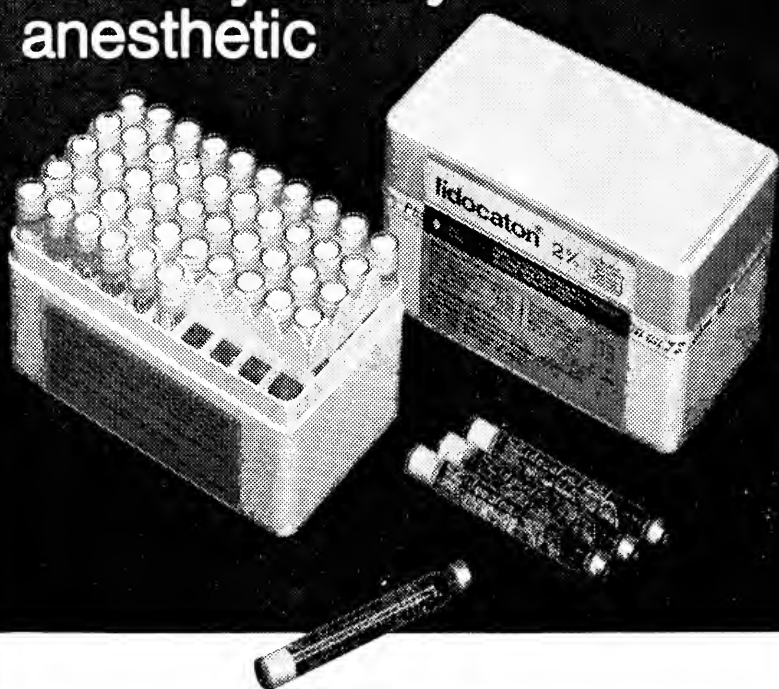
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*Hilton Inn—Raleigh, North Carolina*

*April 16-17, 1972*

*The Carolina—Pinehurst, North Carolina*

*May 14-17, 1972*

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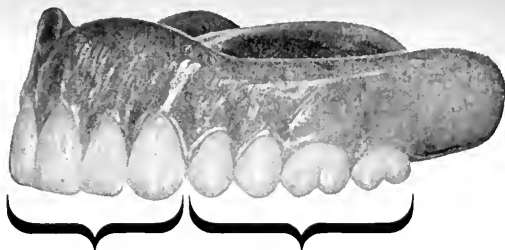
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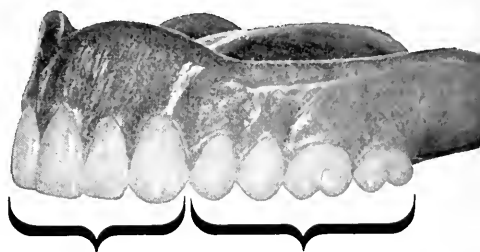
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THE JOURNAL  
of the  
North Carolina Dental Society

A Constituent of the American Dental Association

*Containing the*  
TRANSACTIONS  
*of the*  
116th ANNUAL SESSION

HILTON INN—RALEIGH, NORTH CAROLINA

April 16-17, 1972

THE CAROLINA—PINEHURST, NORTH CAROLINA

May 14-17, 1972

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JAMES A. HARRELL, D.D.S., Secretary-Treasurer.....	Elkin

## SPEAKER OF THE HOUSE

RALPH D. COFFEY, D.D.S.....	Morganton
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## EXECUTIVE SECRETARY

ANDREW M. CUNNINGHAM, B.S.....	Raleigh
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# Report of the President

WADE H. BREELAND, D.D.S.  
Belmont

It is indeed a pleasure to welcome each of you to what we believe to be another outstanding meeting.

It is customary and entirely appropriate in this address to thank the various committee members who have unselfishly worked so effectively in our behalf this past year, and particularly it is appropriate for me to thank the Annual Session Committee members who have worked so diligently to bring this meeting to its fruition.

The success and the failures of this year are adequately documented in our publications.

It is my purpose to comment somewhat concisely, and perhaps with some clarity, on some of the problems facing the profession. In all fairness to myself and to the members and guests of this Annual Session, I will also offer a few postulates, which though disparate, are considered fundamental to these problems.

It is my personal opinion, based on years of experience, observation, and reasoning, that some of the complexities the profession faces today are internally created by complacency and indifference.

We are proud of our heritage and our stature, but much needs to be done for the present and the future. If we are to survive as a profession we must accept our responsibilities and provide for now and the future, so that those who follow us might have an even greater heritage.

Regardless of our inactions of the past, I know of no organization whose members have such broad personal dedication to the profession and to the public, or has such unique capabilities of applying its manifold talents to the concern of dental health services and the protection of the public. We are committed to protect the public in a vital health service, and as responsible professional people, and as an association, we must be responsible and responsive, also, to the challenges and demands which confront us. We must assess our position and we must determine our goals and objectives.

In these times of demands, intervention, and transition, and these days of rapid advancement in methodology and research, the status quo will no longer be sufficient; and we as individuals and as an association should give continuing and serious consideration to plans and programs to meet the increasing demands on the profession.

The profession, today as in the past few years, is being critically analyzed by the public and by Federal health administrators in regard to its ability, its plans, and its programs to meet the ever-increasing demand for dental health care.

We know unquestionably that we do not possess the manpower necessary to meet these increasing demands. We also know we do not have the agencies or programs necessary to administer the dental health programs supported by Federal and State appropriations.

The demands and the influence that Federal intervention is placing on dental education, dental accreditation, and dental licensure as providers of dental health services should be of great concern to the total profession. Every involved agency is expected to devise competent programs within its own approach and philosophy to resolve these problems, but these problems so encompass all agencies that only a coordinated effort of all agencies, working together, can possibly present an approach that will be for the best interest and protection of the total involvement.

The profession of North Carolina and all the agencies must coordinate their efforts and move more realistically into the arena of activity and demand. The profession faces many crucial issues including changing

patterns of oral health delivery, different and expanded roles for auxiliaries, and major alterations even in dental education.

North Carolina has great talent in its members. It should not be wasted. To implement the needed programs within the North Carolina Dental Society, it may be necessary to restructure our committee system and create even new committees, and to combine others with their missions clearly defined. We must keep informed on all crucial issues and make plans to become totally involved in all programs of dental health delivery and a greater use of auxiliary personnel.

Unfortunately, the vast majority of our members are not informed and we do not have the committees to explore and analyze the many issues the profession faces.

In an effort to create plans and programs comparable to all of the involved agencies of the profession, the Executive Committee has approved the formation of an "Interagency Committee of Dentistry" to explore these issues and to devise coordinated means to resolve our problems. This interagency committee of dentistry should have the financial support of the House of Delegates and an adequate budget should be provided for its operation.

The Medicaid program, over the past two years, has been one of the most difficult and persistent problems facing the profession.

The Department of Social Services believes very strongly in the Medicaid program as implemented in North Carolina in 1970. Unfortunately, Medicaid did not receive the public acceptance necessary to assure its continuation as it was structured during the first biennium. The cost of every health service provided under Title XIX had far exceeded the maximum estimate.

The Joint Appropriations Committee apparently was determined, and is still determined, that the cost of providing health care to welfare recipients had to be reduced. Cuts were made by a mathematical formula without due consideration to the ultimate effect upon the Medicaid program and its efforts to provide health care to the needy.

Dentistry has the dubious distinction of being the only profession to have its scope of services limited.

The State Board of Social Services will make other efforts to control cost in the future.

Last Wednesday, May 10, 1972, the State Board of Social Services approved across-the-board cuts in payments to all health providers in the Medicaid program from ninety per cent to eighty per cent of the usual and customary charges for services. The proposed cuts in fees will be presented to the Advisory Budget Commission for approval. If approved by the Budget Commission, this will lead to total disenchantment by the dental profession.

It is time—maybe past time—for the dental profession of North Carolina to collectively take a firm and positive position in regard to percentile fees from Medicaid. It is unfortunate our programs at District and State Meetings do not provide for open forum periods for the membership to decide on a collective consensus of opinions on many matters. I heartily endorse an open forum period at both the District and State Meetings.

In an effort to solve some of the many problems associated with Medicaid, the Dental Care Programs Committee has been working closely throughout the year with the corporate staff of North Carolina Blue Cross and Blue Shield and the Department of Social Services.

One of my objectives during the past year on behalf of the North Carolina Dental Society has been to establish a more effective and a more productive working relationship with North Carolina Blue Cross and Blue Shield.

I believe this objective has been achieved through the outstanding work of the Dental Care Programs Committee.

Several times this year I had the opportunity to meet with the Dental Care Programs Committee and with the President and staff members of Blue Cross and Blue Shield. It was very evident that the management of

Blue Cross and Blue Shield desired to fully cooperate with the Dental Society in all matters of mutual interest, with respect to the Medicaid program and also to the regular Blue Cross—Blue Shield benefits covering services provided by our profession.

I believe it is highly desirable and that it is in our better interest and in the public interest, that we continue to maintain and to strengthen the liaison and working relations with Blue Cross and Blue Shield.

On recommendation of the Dental Care Programs Committee, the Executive Committee requested that a dental representative be included on the Board of Trustees of Blue Cross and Blue Shield.

I am most pleased to report that by the action of the Board of Trustees of Blue Cross and Blue Shield at its April Meeting, the President-Elect of the North Carolina Dental Society will be invited to join the Presidents-Elect of the North Carolina Medical Society and the North Carolina Hospital Association as ex-officio members of the Board of Trustees of Blue Cross and Blue Shield. This action should definitely strengthen the channels of communication, and as a result this relationship should grow in services to the public of North Carolina. In time we hope to have a dental member on the Board of Trustees. I am pleased to make this announcement.

Today, North Carolina is one of sixteen remaining states without an insurance program supported and administered by the profession. I know we are dissatisfied. We detest doled and percentage fees, and token services to patients under the present programs. Yet is it not true that the profession of North Carolina probably has no one to blame but itself?

I believe it was as far back as 1963 that third party health programs and a plan such as the Delta Dental Plans was first presented in the records of the North Carolina Dental Society. Today over two hundred families in North Carolina are by necessity being served under the Delta Dental Plans of California and Ohio because North Carolina does not have at this date sufficient number of signed participating members to qualify for the licensing of the Delta Dental Plans, Inc., of North Carolina as required by the Insurance Commission.

At a special meeting on February 6, 1972, in conjunction with the District Officers Conference a representative of Delta Dental Plans Association from Chicago explained in detail the need for retaining the pro rata clause in the participating agreement, and an explanation of Paragraph No. 7 (the pro rata clause) was sent to every member of the Society.

An attempt was made for an every-member canvass to secure enough required participating members to meet the requirement of the Insurance Commission for the granting of a license.

We now have slightly over seven hundred members signed up to participate in the Plan.

For your information and concern, as directed by the House of Delegates, the North Carolina Dental Society has paid all the expenses for the organization of the North Carolina Delta Dental Plans, Inc., including the legal fees involved, all secretarial and mailing expenses, and the expenses of our representatives to conferences and workshops on the organization, operation, and implementation of the Plan. These expenses were paid out of the general and reserve funds of the Society and the total expenses paid as of March 31, 1972, amounted to \$6,351.00. Adding the \$5,000.00 for Stock in Dental Service Plans Insurance Company makes the total amount to \$11,351.00.

We definitely need our own organization which can offer alternate programs of prepaid dental services to the citizenry of North Carolina.

It is estimated that after the license is secured, it will require from three to five years of concentrated effort to organize and formulate the program, to secure contracts, and to sell enough policies to actually have a productive North Carolina Delta Dental Plans, Inc.

It concerns me and it should concern every member of the Society, that at the direction of the House of Delegates we have spent \$11,351.00 to date out of the general and reserve funds with no requirements or stipulations that any or all of this money be repaid the Society by the North Carolina Delta Dental Plans, Inc., if or when it is financially able to do

so. This expenditure has severely curtailed the services of the Central Office and the objectives and development of programs this administration had hoped to implement. But regardless of the inefficiency of this administration, it is now a primary necessity that we protect our present investment and secure enough participating members to develop our own Delta Dental Plans if North Carolina dentistry does not want to suffer and continue to suffer the indignity of being told what our quotas of token services are to be; what our percentile of fees will be; who our peers may be; have our highly regarded quality of service determined by others than our own profession; and possibly lose our professional image and the private enterprise we now enjoy.

At the March, 1972, meeting of the Trustees of the American Dental Association in response to a resolution passed by the A.D.A. House of Delegates in Atlantic City in support of the Dental Service Plans Insurance Company request, the Trustees authorized the purchase of \$550,000.00 worth of stock in the Dental Service Plans Insurance Company with the understanding that present state investors (that includes North Carolina), be directed to purchase \$490,000.00 worth of the stock held by the A.D.A. This means that North Carolina will be asked to purchase more stock, probably another \$5,000.00 worth or more, in the Dental Service Plans Insurance Company.

There is another development in the making that will support the North Carolina Delta Dental Plans, Inc. This program under development is the Civilian Health and Medical Program of the Uniformed Services—called “CHAMPUS.”

I met for three and one-half hours with Major Brunner, Deputy Director of Dental Affairs, to discuss and become familiar with this program. It is a voluntary-participating insurance type program designed for health benefits, including dentistry, for dependents of active duty service members.

He stated the decision of “CHAMPUS” was to contract with the Delta Dental Plans, Inc., in each state to administer the program.

This program alone would serve thousands of dependents of active duty service members in North Carolina due to the many installations in North Carolina.

I was also informed by Major Brunner that there was a definite plan to reduce the Dental Corps by thirty per cent in the near future and this was a supportive consideration for the development of the Civilian Health and Medical Program of the Uniform Services.

The administration of this program alone could in a major capacity finance the North Carolina Delta Dental Plans, Inc. This should be an added incentive for North Carolina to move rapidly in establishing our own program.

The proposed reduction of the Dental Corps by thirty per cent should have had influence in the decision to remove the stigma to the dental profession of North Carolina by the designation of areas in North Carolina where “adequate civilian dental facilities are not available”—so-called “remote areas.” The members of the profession in these areas have spent much effort and time accumulating adequate data and information to support our request to remove the classification of “remote areas” from the thirty-mile radius of Fort Bragg, Pope Air Force Base, Seymour Johnson Air Force Base, and Camp Lejeune.

These requests and accumulated data were sent to the Assistant Secretary of Defense and to the Department of the Navy.

Last week we were advised by the Assistant Secretary of Defense that authorization to provide dependant dental health care at Fort Bragg and Pope Air Force Base will continue “on a space available basis.”

The Specialty Licensure provision approved by the House of Delegates to be submitted to the 1973 General Assembly with the addition of Subsection (d) of Section I of the proposed provision provides, and I quote:

“Neither this Act nor the Rules and Regulations of the Board shall prohibit a dentist who is generally licensed from restricting his practice to any area of dentistry.”

This subsection (d) of Section I in my opinion does not grant a generally licensed practitioner any privilege that he does not already enjoy. By definition of the new section of the proposed Specialty Licensure provision a general practitioner still will be unable to announce restriction or limitation of his practice to any area of dentistry he may desire.

We need a specialty licensure provision, but this provision will infringe on—or curtail—the privileges or rights of a general practitioner, the exercise of which would place him in conflict with the Code of Ethics or the Practice Act.

The intent and the need of the Specialty Licensure provisions are not questioned, but there still remains in this proposed provision an unquestionable and inherent danger of conflict between what might well develop into an inelastic legal system for regulating dental specialty practice and the much more flexible private regulatory system as reflected within approved requirements and ethical principles approved by the American Dental Association.

Some thought and consideration should be given concerning the Dental Auxiliary Utilization Research Program now being conducted within the strict discipline and quality controls of the University of North Carolina School of Dentistry. This research program is unable to reach its full research potentials due to the restrictions of our practice act.

Recent developments related to health research in dentistry and its impact on the profession gives concern regarding the restrictive permissive utilization of auxiliaries in private practice, and there appears to be a need for full research in the area of expanded function and use of auxiliary personnel to relieve the demand and the expected accelerated demand for dental health care.

As members of the dental health team, you know it is important to maintain the high standards and prestige of the profession. It has taken decades of effort and dedication to reach our present standards and stature; and we must agree that the profession is committed to the responsibility of delivering a maximum amount of the highest quality dental health care to the public. The profession is obligated to sponsor research in expanded utilization of auxiliary personnel if we expect to maintain our premise as a profession. We must turn to research for the development of definite criteria and guidelines if we expect to develop new knowledge and skills for auxiliary personnel. We are fortunate to have the faculty expertise and research available to the profession at our School of Dentistry, but the inflexibility of our practice act prevents total and practical research in this area.

I am further convinced—and you are going to be shocked when I say this—we must develop reasonable alternatives of evaluation of applicants for licensure. The profession of North Carolina has the responsibility to study various alternatives in dental licensure.

There is increasing concern developing in the Congress over the distribution of health care manpower. North Carolina dentistry can no longer disregard an in depth study of various alternatives in licensure, and I urgently request an in depth study of alternative proposals for the profession of North Carolina to consider.

North Carolina now faces the placement of civil service dentists and civil service health personnel by the National Health Service Corps, in areas where health personnel is inadequate, upon request of state or local health agencies. These areas may be remote or inner cities.

As of February, 1972, commissioned dentists have been placed in eight states, and proposals are in process to place dentists in twelve other states by the National Health Service Corps. The Corps desires the endorsement of state societies and/or the State Board of Dental Examiners. These commissioned officers and other personnel are not required by the Corps to have a license to practice in the state to which they are assigned.

It is rumored that recent graduates with or without a license, that have a tenure of service in the Dental Corps may be enlisted to accept these assignments as commissioned officers in lieu of a tenure of service in the Dental Corps of the Armed Services, because at this time the National

Health Corps does not have enough dentists or hygienists enlisted to fill the demand.

These assigned dentists and health personnel are exempt from the control of our Practice Act, but are supposed to work within the Rules and Regulations of the Board. The North Carolina Dental Society should have a policy regarding the endorsement of the request by Public Health Agencies.

At the present time we have three requests for consideration by the Executive Committee.

Our members need to be kept informed on the trends and developments in all areas that will affect the profession, and we need a research committee in the Society to keep the members informed on all trends and programs, so we as a Society can make adequate plans to oppose or support these developments.

We need to develop programs to meet the demands for dental care, because auxiliary expanded utilization is certain to come, and as practices change and develop, so must the educational program in our schools for the resulting auxiliary training that will be required. It will become of paramount importance to provide those auxiliaries already in the work force with the opportunity to broaden their knowledge and skills.

Guidelines are being developed for teaching expanded functions to auxiliaries, and it seems certain that a more flexible approach will be proposed to meet the needs in the use of auxiliary personnel. We, in North Carolina, must plan and prepare educational programs comparable to the needs, as well as a flexible practice act to allow the utilization of auxiliaries trained under these educational programs. These are decisions North Carolina must be prepared to render in the very near future.

The most neglected area of oral health services has been the area of preventive dentistry. The profession in North Carolina owes a debt of gratitude to many of our members for their leadership in the development of workshops on prevention. At every workshop and every clinic the enthusiastic response, the interest, and the attendance has surpassed all expectations.

Preventive dentistry is definitely continuous education of patients in personal oral health care. The contracts of prepaid dental care programs should contain—and they do not contain—payment for services of preventive dentistry and measures should be taken to insist that preventive dentistry be included in the coverage of dental insurance contracts.

The Executive Committee after exhausting every advisable and conceivable means of owning our own Central Office building, finally leased offices, equivalent in area to our present facilities, in the Meredith Woods Professional Building. The rent will be \$8,055.00 per year, which is an increase of \$1,058.00 more than we are presently paying.

Our financial condition presently is not at the level of what is considered a safe margin, and that is to have a reserve equivalent to one year's operation. Presently we are \$29,000.00 below this safe level.

The rent factor will be \$8,055.00 per year, the expenses of secretarial help is on the increase, and if we provide the services we need to provide our members, if we develop the programs we should undertake, if we send our committee chairmen to the conferences they should attend, if we expect to continue to upgrade our scientific sessions at our annual meeting, if we support financially the research and results of the Interagency Committee, and if we expect to keep informed on developments and changes in the profession, it appears that it is time for an in depth study of our financial structure by a special committee.

We need in North Carolina to move forward with adequate plans and programs.

The challenge and the complexities of an ever-changing society requires flexibility of minds, and a dedicated determination, to provide the programs necessary to maintain our professional image and our emblem of service. The combined efforts of splendid individuals such as yourselves, determine the growth, the progress, the strength, and the success of any organization.

North Carolina, this year, became the first state association in the United States to have two student representatives from each class of our School of Dentistry as ex-officio Members of the House of Delegates. This is progress, indeed, and a fine introduction of our future members to organized dentistry. For this I am most grateful.

Before closing, I want to reflect on the perimeter of the potential influence of this association.

As Pascal, the French Philosopher stated, and I quote:

"The least movement is important to all nature. The entire ocean is affected by a pebble."

In the language of the great French mathematician and philosopher, each pebble on the beach and boulder on the heights awaits its potential hour to plunge into an ocean — there to lift its tides, and with endless swells meet the shores of the whole perimeter. Vast as the area of the restless tides of time may be, every act, every thought, hurled into its placid or furious surface, disturbs to the end, and marks or mars the beaches.

So every leader, every thinker, and every member of our association is constantly breaking the calm surface, or the angry turbulence of surrounding seas of professional development or demonstrating object apathy.

In closing, Ladies and Gentlemen, it is inspiration, motivation, and vision that will pull us to the perimeter of our objectives and responsibilities and as an organization we want the best for our profession, for society, and for ourselves. This Society will meet the challenges through action—not reaction.

Thanks for your patience and your indulgence. Your many kind considerations this past year are only superceded by the deep respect and personal admiration I have for each of you and especially my pleasure of working with such exceptionally fine citizens of the dental community.

I thank you for listening.

# Report of the Secretary- Treasurer

JAMES A. HARRELL, D.D.S.  
Elkin

## **NORTH CAROLINA DENTAL SOCIETY** **AUDIT FOR FISCAL YEAR ENDED MAY 31, 1972**

The Officers and Directors  
North Carolina Dental Society

We have examined the balance sheets and related statements of income, expenses and fund balances for the General Fund, Relief Fund and Development Fund, together with supporting schedules, of the North Carolina Dental Society for the year ended May 31, 1972. Our examination was made in accordance with generally accepted auditing standards applicable to accounts maintained on the cash basis and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

Inasmuch as the records are maintained on the cash basis of accounting, income earned but not received and expenses incurred but not paid, if any, are not reflected in the accompanying financial statements.

In our opinion, the accompanying financial statements present fairly the financial position of the North Carolina Dental Society at May 31, 1972, and the results of its cash transactions for the year then ended, on a basis consistent with that of the preceding year.

LYNCH, McMILLAN AND ROBERTSON

June 26, 1972

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Exhibit E	Statement of Income, Expenses and Fund Balance

#### **Development Fund:**

Exhibit F	Balance Sheet
Exhibit G	Statement of Income, Expenses and Fund Balance

#### **Capital Fund:**

Exhibit H	Balance Sheet
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## EXHIBIT A

**GENERAL FUND  
BALANCE SHEET—MAY 31, 1972**

**ASSETS**

<b>Cash:</b>		
Checking account—First Citizens Bank & Trust Co., Raleigh, North Carolina.....	\$ 1,763.85	
Savings account—First Citizens Bank & Trust Co., Raleigh, North Carolina.....	100.00	
On deposit—R. S. Dickson, Powell, Kistler & Crawford, Raleigh, North Carolina.....	437.50	\$ 2,301.35
<b>Marketable securities, at cost (market value \$59,940.00) .....</b>		<b>64,377.57</b>
<b>Stock in Dental Service Plans Insurance Company, at cost.....</b>		<b>5,000.00</b>
		<u><u>\$ 71,678.92</u></u>

**LIABILITIES AND FUND BALANCE**

<b>Liabilities .....</b>	<b>\$ —</b>	
<b>Fund balance:</b>		
Appropriated:		
Prior years:		
Library and History Committee.....	\$ 1,600.00	
For study of central office needs.....	1,000.00	
For purchase of stock in Dental Service Plans Insurance Company .....	\$ 5,000.00	
Current year expenditures .....	5,000.00	
Current year:		
Insurance consultant services.....	2,500.00	5,100.00
Unappropriated .....		66,578.92
		<u><u>\$ 71,678.92</u></u>

## EXHIBIT B

**GENERAL FUND  
STATEMENT OF INCOME, EXPENSES AND UNAPPROPRIATED  
FUND BALANCE  
YEAR ENDED MAY 31, 1972**

<b>Fund balance—May 31, 1971.....</b>	<b>\$ 58,131.95</b>
<b>Income:</b>	
Dues and penalties collected.....	\$175,935.50
Revenue from Annual Session.....	15,576.00
Revenue from publications.....	6,458.04
Interest on savings.....	148.99
Interest on corporate bonds.....	875.00
Dividends on corporate stocks.....	1,123.20
Net gains on sales of securities.....	4,621.90
Expense reimbursements, refunds and sundry .....	1,228.00
<b>Total income .....</b>	<u><u>\$205,966.63</u></u>

**Expenses:**

## Dues and penalties remitted:

American Dental Association..	\$ 93,264.50	
A.D.A. Relief Fund.....	1,515.00	
First District,		
North Carolina .....	2,565.00	
Second District,		
North Carolina .....	3,385.00	
Third District,		
North Carolina .....	3,360.00	
Fourth District,		
North Carolina .....	2,225.00	
Fifth District,		
North Carolina .....	2,105.00	
Refunds .....	404.00	\$108,823.50

Central Office expense.....	56,203.44	
Journal expense .....	7,009.78	
Newsletter .....	2,466.16	
Directory .....	1,025.62	
Dental Practice Act Committee .....	2,596.09	
Dental Service Corporation Committee.....	2,015.94	
Peer review .....	33.69	
District officers' conference.....	361.34	
Annual Session expense.....	12,239.98	
Reimbursement of Delegates and		
Representatives .....	6,346.62	
Contributions .....	140.00	
Memberships .....	757.50	

**Total expenses** ..... **\$200,019.66**

**Net income** ..... **\$ 5,946.97**

Fund balance before other deductions and		
other credits .....	\$ 64,078.92	
Other deductions:		
Transfer to appropriated funds.....	(2,500.00)	
Other credits:		
Transfer from appropriated funds (prior		
year) to assets.....	5,000.00	
<b>Fund balance—May 31, 1972.....</b>	<b>\$ 66,578.92</b>	

**EXHIBIT C**

**GENERAL FUND**  
**DETAIL SCHEDULE OF EXPENSES**  
**YEAR ENDED MAY 31, 1972**

**Central Office expenses:**

Salaries and payroll taxes.....	\$ 35,862.95
Rent .....	6,996.24
Supplies .....	1,865.91
Office machine maintenance.....	600.20
Telephone .....	3,128.42
Postage .....	1,075.06
Travel—Executive Secretary .....	1,070.70
Hazard insurance .....	169.00
City and county taxes.....	120.09
Newsclipping service .....	228.00
Employee insurance .....	816.40
Audit .....	475.00
Legal counsel .....	2,374.35
Investment counsel .....	583.50

Addressing service .....	\$ 623.91
Miscellaneous .....	213.71
	<u>\$ 56,203.44</u>

**Annual Session expenses:**

Arrangements .....	\$ 3,658.30
Exhibits .....	2,082.06
Entertainment .....	2,509.48
House of delegates.....	708.30
Program .....	2,808.13
Publicity .....	327.31
Clinics .....	110.00
Necrology .....	36.40
	<u>\$ 12,239.98</u>

**EXHIBIT D**

**RELIEF FUND  
BALANCE SHEET—MAY 31, 1972**

**ASSETS**

Checking account—North Carolina National Bank, Raleigh, North Carolina.....	\$ 686.67	
Savings account—First Citizens Bank & Trust Co., Raleigh, North Carolina.....	221.70	
On deposit—R. S. Dickson, Powell, Kistler & Crawford, Raleigh, North Carolina.....	2,993.72	\$ 3,902.09
Marketable securities, at cost (market value \$61,570.00) .....		56,801.44
		<u>\$ 60,703.53</u>

**LIABILITIES AND FUND BALANCE**

Fund balance .....	<u>\$ 60,703.53</u>
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**EXHIBIT E**

**RELIEF FUND  
STATEMENT OF INCOME, EXPENSES AND FUND BALANCE  
YEAR ENDED MAY 31, 1972**

Fund balance—May 31, 1971.....	\$ 57,929.92
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**Income:**

A.D.A. Relief Fund.....	\$ 2,218.00
Interest on savings.....	11.63
Interest on corporate bonds.....	1,143.76
Dividends on corporate stocks.....	1,737.20
Net gains on sale of securities.....	2,361.52
Reinstatement fees .....	10.00

**Total income** ..... \$ 7,482.11

**Expenses:**

Relief grants .....	\$ 4,000.00
Investment counsel .....	583.50
Audit .....	125.00

**Total expenses** ..... \$ 4,708.50

**Net income** ..... 2,773.61

Fund balance—May 31, 1972.....	<u>\$ 60,703.53</u>
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## EXHIBIT F

**DEVELOPMENT FUND  
BALANCE SHEET—MAY 31, 1972**

**ASSETS**

**Cash:**

Checking account—First Union National Bank, Raleigh, North Carolina.....	\$ 204.19
Savings account—First Federal Savings & Loan Association, Durham, North Carolina.....	228.07
	<u>\$ 432.26</u>

**LIABILITIES AND FUND BALANCE**

<b>Fund balance</b> .....	<u><u>\$ 432.26</u></u>
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## EXHIBIT G

**DEVELOPMENT FUND  
STATEMENT OF INCOME, EXPENSES AND FUND BALANCE  
YEAR ENDED MAY 31, 1972**

<b>Fund balance—May 31, 1971</b> .....	\$ 2,221.51
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**Income:**

Interest on savings.....	\$ 108.02
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**Expenses:**

Office equipment lease.....	\$ 330.46
Purchase of office equipment....	1,531.21
Office furniture repair.....	35.60

<b>Total expenses</b> .....	<u>1,897.27</u>
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<b>Net loss</b> .....	(1,789.25)
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<b>Fund balance—May 31, 1972</b> .....	<u><u>\$ 432.26</u></u>
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## EXHIBIT H

**CAPITAL FUND  
BALANCE SHEET—MAY 31, 1972**

**ASSETS**

<b>Furniture and equipment, at cost</b> .....	\$ 14,406.37
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**LIABILITIES AND FUND BALANCE**

**Fund balance—May 31, 1971:**

Investment in fixed assets.....	\$ 12,875.16
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**Additions:**

1 portable recorder .....	\$ 255.44	
1 Gregson chair .....	120.84	
1 adding machine carrying case.....	16.13	
1 3M copying machine.....	1,138.80	1,531.21
	<u>1,138.80</u>	<u>1,531.21</u>

<b>Fund balance—May 31, 1972</b> .....	<u><u>\$ 14,406.37</u></u>
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# Report of the Executive Secretary

ANDREW M. CUNNINGHAM  
Raleigh

As your executive secretary I am submitting herewith my seventeenth annual report as required by the *Bylaws*.

The duties and responsibilities are clearly outlined in the *Bylaws*, and to the best of my ability I have tried to fulfill all of them, insofar as staff and time would permit.

**Membership.** In the fall of 1971 all five Districts amended their *Constitution and Bylaws* authorizing the Executive Committee to accept new members by majority vote. This means that Districts can now elect new members at any time during the year and not just at the annual meeting as had previously been the case. In my report to the 1971 House of Delegates I recommended that a mechanism be developed to permit the election of new members more than once annually. The House adopted a resolution urging the Districts to provide such a means of electing new members and the Districts complied. A glance at the Membership Report will reveal that the new system is working well.

First of all, 85 new members were elected at the District meetings. This is a record high for new members elected at annual meetings. Since the annual meetings, 14 additional new members have been elected (through March 21, 1972). If the Districts had not amended their *Constitution and Bylaws*, these 14 new members could not have been accepted until the fall of 1972.

**Annual Session.** A little over a year ago The Carolina, in fact practically the whole village of Pinehurst, was sold to The Diamond Head Corporation. As a result the management of The Carolina was changed completely. We have been enjoying good relationship with the new management and have received excellent cooperation, but the change-over was not without problems because we had to learn their way of doing things and vice versa.

In the summer of 1971, the entire lobby and the dining room of The Carolina were completely remodeled. By the time of our annual session approximately 100 of the rooms will have been renovated.

In the remodeling process, the Exhibition Hall was converted to office space. This necessitated relocating the commercial exhibits in other areas of the hotel and the designing of a new floor plan.

To further complicate matters, the Railway Express Office in Southern Pines was closed and an alternate means of getting the exhibits to Pinehurst had to be worked out, since there are no motor terminal facilities in the Pinehurst area.

In spite of these difficulties, we think the 1972 annual session will come up to everyone's expectations, even though some adjustments had to be made in the planning. There will be some changes in the format from previous years, but we think the members will find most of these changes will result in a good convention.

**Relocation of Central Office.** Since May 1967 we have been happily located in a building which we specifically designed for the Central Office. Unhappily, about three years ago the State of North Carolina purchased the property and has since notified us that we must vacate the building when the present lease expires August 31, 1972. Repeated

attempts to get the State Department of Administration to extend the lease have failed.

An exhaustive search was made to find suitable property on which the Society could build its own building. However, on the advice of the Society's CPA the Executive Committee abandoned this plan. Our CPA advised that for tax purposes it would be more economical and feasible for the Society as a non-profit organization, to continue to lease office space rather than build its own building.

Consequently, negotiations are now underway to lease approximately 1,611 square feet in the newly constructed Meredith Woods Professional Building effective on or about August 1, 1972. We are reluctant to move from our present quarters but we are convinced that the new location will prove highly satisfactory for our purposes.

Meredith Woods Professional Building is located just off the Raleigh Beltline at Lake Boone Trail exit. Actually it is more easily accessible than our present site. This will be a distinct advantage to members coming into Raleigh. We can easily be found and the traffic problem in this area is minimal.

**N. C. Delta Dental Plans.** The 1963 House of Delegates adopted a resolution authorizing the establishment of a dental service corporation in North Carolina. Finally, in October 1970 N. C. Delta Dental Plans was incorporated but not licensed to underwrite. The Insurance Commissioner indicated that approximately \$45,000 in capital and the employment of a qualified executive director would be required before the corporation could be licensed.

To date over 700 dentists have signed participating agreements and have paid the \$50 enrollment fee. This will provide approximately \$35,000 in capital funds, so we are reasonably within reach of the \$45,000 capital required by the Insurance Commissioner. An intensive member-to-member campaign was launched early in 1972 and it promises to achieve the desired results. However, finding and employing a competent executive director may well prove a very difficult task.

Since 1963, the Society has spent over \$6,300 on the organization of a dental service corporation. This does not include administrative and secretarial support provided by the Central Office staff.

**Staff Changes.** With regret we accepted the resignation of Mrs. Kathryn P. Montague effective January 31, 1972. Mrs. Montague has served as financial secretary in the Central Office since October 1968. She was an excellent staff member. We hated to see her leave, but Mrs. Montague felt that she should spend more time at home with her two children and for this we cannot blame her. We are grateful to her for 3½ years of capable and efficient service to the Central Office and the Society. Fortunately, Mrs. Montague agreed to continue to work through May 1972 on a part-time basis, and at least see us through the House of Delegates and our annual session.

I am happy to report that Mrs. Jean G. Pace of Raleigh assumed the responsibility of financial secretary in mid-January. In the short time she has been with us Mrs. Pace has proved to be a valuable employee. She joins our staff after 20 years experience with the Wildlife Resources Commission in accounting and secretarial work.

**1971-72 Budget.** Barring unforeseen exenses in the final months of fiscal 1971-72, it is estimated that we should end this fiscal year with a surplus of approximately \$3,000. Thus, this administration is continuing to show fiscal responsibility in the expenditure of Society funds. It is unusual in this day and time of spiralling costs for any organization and especially the government, to live within its budget. It is even more unusual for an organization to show a surplus at the end of the year.

**Thanks.** As I complete my seventeenth year as your executive secretary my thanks and appreciation go to the State and District Officers, and to all the members for their support and cooperation.

I must also extend my sincere thanks to the Central Office staff members for their loyalty. I have worked with them daily and I am convinced that the Society is fortunate in having employees of their caliber and talent in the Central Office.

# Minutes of Executive Committee

FAY H. CULBRETH  
*Chairman*  
Charlotte

MAY 11, 1971  
JULY 10, 1971  
OCTOBER 24, 1971  
NOVEMBER 17, 1971  
DECEMBER 5, 1971  
JANUARY 8, 1972  
JANUARY 9, 1972  
MARCH 12, 1972  
APRIL 15, 1972

## PINEHURST, NORTH CAROLINA

May 11, 1971

**Call to Order.** The Executive Committee convened at The Carolina, Pinehurst, on Tuesday, May 11, 1971. Dr. Fay H. Culbreth, chairman, called the meeting to order at 8:30 a.m.

**Roll Call.** Officers present: W. L. Hand, Jr., president; Wade H. Breeland, president-elect; M. Lamar Dorton, vice president; Joseph M. Johnson, secretary-treasurer.

Members of Executive Committee: Fay H. Culbreth, chairman; C. W. Horton, C. W. Poindexter.

New members of Executive Committee: Robert H. Gainey, newly-elected vice president; James A. Harrell, newly-elected secretary-treasurer.

Staff member: Andrew M. Cunningham, executive secretary.

**Introduction of New Members.** Dr. Culbreth welcomed the following to the Executive Committee: Robert H. Gainey, newly-elected vice president; and James A. Harrell, newly-elected secretary-treasurer.

Dr. Breeland announced the following appointments: Fay H. Culbreth, chairman, Executive Committee for 1971-72; William A. Current, member of Executive Committee for a three year term.

**Editor-Publisher.** On motion by Dr. Breeland, seconded by Dr. Johnson, Dr. Benjamin R. Baker was re-appointed editor-publisher for 1971-72.

**Executive Secretary.** On motion by Dr. Breeland, seconded by Dr. Johnson, Mr. Andrew M. Cunningham was re-appointed executive secretary for 1971-72 with a salary according to the schedule of payment adopted by the 1966 House of Delegates.

**1973 Annual Session.** It was noted that the Society in General Session, May 10, 1971, voted to hold the 117th Annual Session at The Carolina, Pinehurst, May 13-16, 1973. On motion by Dr. Johnson, seconded by Dr. Breeland, these dates are to be confirmed with The Carolina.

As a means of assuring a maximum head count in the headquarters hotel during our annual session, it was suggested that the hotel consider requiring a deposit on reservations and specifying an earlier check-in hour.

**Legal Counsel.** Dr. Johnson moved that the firm of Joyner and Howison of Raleigh be retained as legal counsel for the Society for 1971-72. Dr. Horton seconded the motion and it was carried.

**Approval of Minutes.** On motion by Dr. Breeland, seconded by Dr. Horton, the minutes of April 22, 1971, were approved.

**Secretaries Management Conference.** On motion by Dr. Poindexter,

seconded by Dr. Johnson, the executive secretary was authorized to attend at Society expense the Secretaries Management Conference at ADA Headquarters, Chicago, June 7-9, 1971.

Dr. Breeland announced that Dr. James A. Harrell, newly-elected secretary-treasurer, would also represent the Society at the Conference.

**Finance Committee.** Dr. Breeland announced the appointment of the following to the Finance Committee: Dr. Johnson, chairman, Dr. Harrell and Dr. Horton.

**Survey of Central Office.** Dr. Breeland announced the appointment of Dr. James A. Harrell to the survey of Central Office Committee.

**Out-of-Pocket Expenses for Committee Members.** Dr. Breeland moved that members of standing and special committees be requested to report out-of-pocket expenses incurred in the performance of their duties. Dr. Poindexter seconded the motion and it was carried.

**Next Meeting.** Dr. Horton moved that the next meeting of the Executive Committee be held in Charlotte at a place to be designated by Dr. Breeland, the week-end of July 31-August 1, 1971. Dr. Harrell seconded the motion and it was carried.

**Expression of Appreciation.** Dr. Hand expressed his appreciation to Executive Committee members for their loyalty and dedication during his administration.

**Adjournment.** On motion by Dr. Harrell, seconded by Dr. Gainey, the meeting was adjourned at 9:35 a.m.

JOSEPH M. JOHNSON, D.D.S.  
Secretary-Treasurer

## RALEIGH, NORTH CAROLINA

July 10, 1971

**Call to Order.** The Executive Committee convened at the Central Office, Raleigh, on Saturday, July 10, 1971. Dr. Fay H. Culbreth called the meeting to order at 2:35 p.m. Dr. James A. Harrell led in prayer.

**Roll Call.** Officers present: Wade H. Breeland, president; Joseph M. Johnson, president-elect; James A. Harrell, secretary-treasurer; Benjamin R. Baker, editor-publisher.

Members of Executive Committee: Fay H. Culbreth, chairman; William A. Current, Charles W. Horton.

Staff Member: Andrew M. Cunningham, executive secretary.

**Approval of Minutes.** The minutes of May 11, 1971, were approved on motion by Dr. Breeland, seconded by Dr. Harrell.

**Audit for Fiscal 1970-71.** The audit of Society funds for fiscal 1970-71 prepared by Lynch, McMillan and Robertson was approved on motion by Dr. Johnson, seconded by Dr. Horton.

**Budget 1971-72.** Dr. Johnson, chairman, Finance Committee, presented a proposed budget for fiscal 1971-72 totalling \$92,095.00. Other members of the Finance Committee are Dr. Harrell and Dr. Horton. The recommended budget was approved on motion by Dr. Breeland, seconded by Dr. Harrell.

**Dental Service Plans Stock.** It was noted that resolution 27-1971-H adopted by the 1971 House of Delegates allocated \$5,000 of reserve funds for the purchase of stock in Dental Service Plans Insurance Company. Dr. Breeland moved that purchase of this stock be deferred until there is sufficient cash on hand from dues and exhibit income. Dr. Harrell seconded the motion and it was carried.

**Retirement Program.** On motion by Dr. Breeland, seconded by Dr. Harrell, the Finance Committee was directed to conduct a feasibility study of a retirement benefits program for employees and submit a report and recommendations to the Executive Committee at the earliest possible date.

**Per diem and travel allowance.** Dr. Johnson moved that the per diem paid to delegates, alternates, and Society representatives to conferences be increased from \$40 to \$50 per day and that they be allowed 12c per mile for travel for personal automobile. Dr. Horton seconded the motion and it was carried.

**Travel by Executive Secretary.** Dr. Breeland moved that the Executive Secretary be reimbursed 12c per mile for travel by personal automobile on official Society business. Dr. Johnson seconded the motion and it was carried.

**House of Delegates.** It was noted that resolution 9-1971-H adopted by the 1971 House of Delegates amended the *Bylaws* to provide that the Executive Committee shall determine when and where the House of Delegates shall meet annually.

It was suggested that the 1972 House of Delegates meet one month prior to the Annual Session and that committee reports be requested by March 1. The president was requested to recommend definite dates for the meeting of the 1972 House of Delegates after conferring with the executive secretary.

**Communications.** The following communications were received for information:

A letter from Mrs. John C. Brauer, thanking the Society for the resolution and tribute in memory of the late Dr. John C. Brauer adopted by the Society at its 115th Annual Session; and

A letter from Pilot Life Insurance Company urging the Society to support the National Health Care Act of 1971 (H.R. 4349 and S. 1490) proposed by the insurance industry.

**N.C.A.P. Resolutions.** Four resolutions adopted by the Board of Directors of the N. C. Association of Professions were received with the request that the Society endorse them.

On motion by Dr. Horton, seconded by Dr. Johnson, the resolution pertaining to the Intangible Tax — Miller Clinic Case was endorsed in principle only.

On motion by Dr. Johnson, seconded by Dr. Horton, the chairman of the Executive Committee was authorized to endorse the other three resolutions after he conferred with the president of the N.C.A.P. and determined that they were in the best interest of dentistry.

**Medicaid.** It was noted that the 1971 Appropriations Act adopted by the General Assembly on June 30 restricted dental services to Medicaid recipients and limited payment for these services to "90 per cent of allowable, usual and customary charges."

On motion by Dr. Johnson, seconded by Dr. Horton, the executive secretary was directed to notify the membership by letter of the cut-backs in Medicaid.

**Program Committee Request.** Dr. Breeland announced that the Program Committee would request an allocation of \$3,000 for the 1972 Annual Session.

**Secretaries Management Conference.** Dr. Harrell submitted a report on the 22nd Annual Management Conference held at ADA Headquarters in Chicago, June 7-9, 1971 which he and the executive secretary attended. Copies of the report are to be distributed to members of the Executive Committee.

**Request from N. C. Delegation.** A request from the Delegation to the ADA that the Society pay the expenses of a third alternate delegate was refused on motion by Dr. Breeland, seconded by Dr. Johnson.

**Next Meeting.** It was tentatively agreed that the Executive Committee would meet next on Sunday, October 24 at 12:00 noon at the Central Office during the Fourth District Meeting.

**Adjournment.** The meeting was adjourned at 6:00 p.m.

JAMES A. HARRELL, D.D.S.  
Secretary-Treasurer

## BUDGET

North Carolina Dental Society  
Fiscal 1971-72

Adopted by the Executive Committee July 10, 1971

	Estimated Income 1971-72	Actual Income 1970-71
<b>ESTIMATED INCOME</b>		
State Dues .....	\$66,500.00	\$63,862.00
Annual Session .....	15,380.00	15,393.00
Publications		
Journal .....	\$ 6,300.00	\$ 5,705.00
Directory .....	100.00	97.00
Interest & Dividends		
Interest on Savings....	—0—	\$ 696.00
Interest on Corporate bonds .....	\$ 1,250.00	1,253.00
Dividends on Corporate stocks ....	815.00	2,763.00
Net gains from sale of securities.....	1,150.00	1,138.00
Expense Reimbursement .....	600.00	614.00
Miscellaneous .....	—0—	30.00
<b>TOTAL</b> .....	<u>\$92,095.00</u>	<u>\$89,602.00</u>
<b>EXPENSES</b>		
	<b>Budgeted 1971-72</b>	<b>Expended 1970-71</b>
Central Office Expense		
Salaries & payroll taxes .....	\$34,090.00	\$31,447.00
Rent .....	6,996.00	6,996.00
Supplies .....	1,800.00	1,607.00
Office machine maintenance .....	650.00	594.00
Telephone .....	3,700.00	3,752.00
Postage .....	1,475.00	1,104.00
Travel-Exec. Sec. ....	1,960.00	1,961.00
Hazard insurance .....	238.00	238.00
City & county taxes....	130.00	130.00
Newsclipping service ....	216.00	180.00
Employee insurance ....	760.00	626.00
Audit .....	475.00	275.00
Legal Counsel .....	500.00	422.00
Investment Counsel .....	460.00	459.00
Addressing service .....	350.00	350.00
Miscellaneous .....	100.00	107.00
Annual Session .....	11,500.00	11,150.00
Publications		
Journal .....	\$ 7,650.00	\$ 7,204.00
Newsletter .....	2,125.00	2,116.00
Directory .....	1,310.00	1,234.00
Committees & Conferences.....	1,500.00	3,532.00
Reimbursement of officers, delegates, representatives to conferences.....	9,000.00	9,119.00
Contributions .....	300.00	310.00
Memberships .....	937.00	837.00
<b>TOTALS</b> .....	<u>\$88,222.00</u>	<u>\$85,750.00</u>
Contingent Fund .....	3,873.00	
	<u>\$92,095.00</u>	

## RALEIGH, NORTH CAROLINA

October 24, 1971

**Call to Order.** The Executive Committee convened at the Central Office, Raleigh, on Sunday, October 24, 1971. Dr. Fay H. Culbreth, chairman, called the meeting to order at 9:00 a.m. Dr. W. L. Hand, Jr., led in prayer.

**Roll Call.** Officers present: Wade H. Breeland, president; Joseph M. Johnson, president-elect; Robert H. Gainey, vice president; James A. Harrell, secretary-treasurer; Benjamin R. Baker, editor-publisher.

Executive Committee members: Fay H. Culbreth, chairman; William A. Current, W. L. Hand, Jr., Charles W. Horton.

Staff Member: Andrew M. Cunningham, executive secretary.

Others present: J. S. D. Nelson, chairman, Insurance Committee; Walter H. Finch, Jr., chairman, Central Office Site Committee.

**Approval of Minutes.** The minutes of July 10, 1971 were approved as corrected on motion by Dr. Harrell, seconded by Dr. Breeland.

**Report of Secretary-Treasurer.** The report of the Secretary-Treasurer as of September 30, 1971 was received for information.

Dr. Johnson moved that in the future the Executive Secretary be authorized to sign checks drawn on Society accounts in addition to the Secretary-Treasurer, and that a listing of all checks drawn on Society accounts be distributed monthly to members of the Executive Committee. Dr. Harrell seconded the motion and it was carried.

**Insurance Committee Report.** Dr. J. S. D. Nelson, chairman, Insurance Committee, reported that the Committee recommended the employment of Mr. Harvey Sarner as insurance consultant to the Society at an initial cost of \$2,000 plus travel expenses. He stated that the services of Mr. Sarner in this capacity could result in a savings in premium dollars to members participating in Society sponsored insurance programs.

Dr. Breeland moved that the report be received for information and action on it be deferred until the next meeting. Dr. Gainey seconded the motion. The motion was defeated.

Dr. Horton moved that the Executive Committee authorize the expenditure of \$2,500 from the Contingent Fund for the initial phase of Mr. Sarner's services. Dr. Johnson seconded the motion. The motion was defeated.

Dr. Harrell moved that action on the report be deferred until the next meeting and that Mr. Sarner be requested to submit a contract for the work he proposed to undertake for the consideration of the Executive Committee. Dr. Hand seconded the motion and it was carried.

Dr. Nelson reported that he had been notified by N. C. Blue Cross and Blue Shield, Inc., that they had experienced an unfavorable loss ratio in the Society-sponsored Medical-Hospital-Surgical Plan during the past 12 months and that it would be necessary to increase premium rates effective January 15, 1972. He noted that the Insurance Committee, in view of the circumstances, had agreed to a 90 day advance notice of the rate increase, rather than the 120 advance notice specified in the contract.

**Central Office Site Committee Report.** Dr. Walter H. Finch, Jr., chairman, Central Office Site Committee, reported that the Committee had examined and considered numerous proposals for relocating the Central Office when the lease on the present property expires in September 1972.

He stated that the Committee suggested three avenues of approach:

- (1) To buy an existing building;
- (2) To rent suitable space; or
- (3) To buy a lot and build.

He outlined the best offerings in each of the above three categories which the Committee had investigated.

He requested the Executive Committee to give some direction as to how his Committee should proceed.

Dr. Breeland moved that the Central Office Site Committee be directed to seek an appropriate lot on which a building could be built and report at the next meeting of the Executive Committee. Dr. Current seconded the motion and it was carried.

Dr. Johnson moved that Mr. Cunningham be requested to ask legal counsel for his opinion on whether the Indenture of Trust of the Relief Fund would permit funds to be borrowed by the Society for investing in property. Dr. Current seconded the motion and it was carried.

**Reports on Conferences.** A report on the Second Conference on Practice Administration, held at the ADA Headquarters in Chicago was submitted by Dr. M. W. Aldridge who represented the Society at the Conference. The report was received for information with commendation on motion by Dr. Horton, seconded by Dr. Harrell.

A report on the 22nd Annual Management Conference held at ADA Headquarters in Chicago June 7-9, 1971 was submitted by Dr. James A. Harrell, secretary-treasurer, who represented the Society at the Conference. The report was received for information with commendation on motion by Dr. Gainey, seconded by Dr. Johnson.

**Communications.** A letter was received from the N. C. Rural Safety Council inviting the Society to renew its membership in the Council. The annual membership fee is \$15.00. Dr. Harrell moved that the Society renew its membership in the N. C. Rural Safety Council for the coming year. Dr. Breeland seconded the motion and it was carried.

A letter from Mr. Peter Goulding, Director of Communications, American Dental Association, referring to the *Manual for Component Dental Societies* concerning referral service provided by local societies, and suggesting that local societies in North Carolina should provide such service.

Dr. Johnson moved that Mr. Cunningham determine if this were official ADA policy. Dr. Harrell seconded the motion and it was carried.

A letter from Dr. W. Luke Johnson of Greensboro, complaining that a collection service to which he had subscribed had proven very unsatisfactory.

Dr. Current moved that an announcement be included in a future *Newsletter* advising members to check with their local Better Business Bureau or Chamber of Commerce before subscribing to any collection service, and that a letter be sent to Dr. Johnson informing him of the action of the Executive Committee. Dr. Breeland seconded the motion and it was carried.

A letter from the N. C. Hospital Association requested a donation of \$1,500 for partial funding of reprinting the booklet titled "Educational Programs for Health Careers in North Carolina." It was noted that all but one of the organizations which underwrote the cost of the previous edition were public or state agencies and that the majority of prospective underwriters for this edition would be public or state agencies.

Dr. Johnson moved that the request be denied with regret. Dr. Harrell seconded the motion and it was carried.

A letter from Pinehurst, Inc., stating that they were still interested in continuing convention and meeting business, despite rumors to the contrary, was received for information.

A letter from Donald L. Henson Co., Inc. recommended that a no-load mutual fund be used as a vehicle for funding a retirement program for employees of the Central Office. Mr. Cunningham was requested to follow-up on this recommendation.

A letter from H. F. Seawell, Jr., attorney in Carthage complained about the treatment of a patient by a dentist member. Dr. Current moved that the letter be submitted to legal counsel for his advice on how to answer this letter. Dr. Breeland seconded the motion and it was carried.

**Waiver of Dues.** An application for Waiver of Dues because of permanent disability from Dr. Raymond R. Meisel of Greensboro, a member of

the Third District, was approved on motion by Dr. Gainey, seconded by Dr. Johnson.

**Renovations at The Carolina.** Mr. Cunningham reported that extensive renovations at The Carolina would require some changes in the format of the annual session program in May, particularly in regard to commercial exhibits, which might result in some revenue loss. He stated that every effort would be made to adjust the floor plan so that any loss of revenue would be at a minimum.

**1972 House of Delegates.** Mr. Cunningham reported that the most feasible dates for the meeting of the 1972 House of Delegates would be April 6-9 or April 13-16. He stated that the Velvet Cloak in Raleigh would be available for April 6-9, and that he was checking The Hilton, also in Raleigh, to determine if it would be available either date.

Dr. Johnson stated that Fox Fire in Pinehurst would be available either date and outlined the housing accommodations, meeting rooms, and recreation facilities which Fox Fire could offer.

Mr. Cunningham stated that Dr. Ralph D. Coffey, Speaker of the House, had advised that the dates of April 6-9 were in conflict with a meeting of the ADA Council on Insurance, of which he is chairman.

Dr. Breeland moved that the 1972 House of Delegates be convened at The Hilton in Raleigh, April 13-16; if this is not possible, then the House will be convened at the Velvet Cloak in Raleigh, April 6-9. Dr. Harrell seconded the motion and it was carried.

**Remarks of the President.** Dr. Breeland expressed his concern over the apparent lack of information by members concerning what is happening in dentistry on the national level, particularly in regard to national health programs now under consideration by Congress.

Dr. Hand moved that the President appoint a committee to devise ways and means of disseminating information to the membership to keep them better informed of developments in dentistry on the national level. Dr. Harrell seconded the motion and it was carried.

**Remarks of President-Elect.** Dr. Johnson stated that it had been emphasized at previous Management Conferences in Chicago that dentists must get involved in politics. He also stated that many constituent societies had annually been sending a group to Washington to talk with congressmen about current and proposed health legislation.

Dr. Johnson moved that the president appoint a committee to organize a liaison group to meet with legislators on the national and state levels. Dr. Gainey seconded the motion and it was carried.

Dr. Johnson stated that he had recently received a fee schedule and a new claim form to be used with the State School Health Program. He pointed out that the fee schedule needed revision and updating and that the new claim form, which required submission in triplicate, would be burdensome to dentists participating in the program.

It was noted that resolution 16-1971-H adopted by the 1971 House of Delegates requested the Dental Care Programs Committee "to review the 1967 State Agency Dental Fee Schedule, and negotiate with the appropriate state agency for a revision of fees equal to or greater than the level of those fees established by the State Industrial Commission Fee Schedule."

In accord with this resolution, the matter of a revision of the fee schedule and claim forms will be referred to the Dental Care Programs Committee for action.

**Next Meetings.** It was agreed that the Executive Committee would next meet at the Velvet Cloak in Raleigh on Saturday, December 4, 1971 at 9:00 a.m., just prior to the convening of the District Officers Conference.

It was also agreed that the Executive Committee would meet jointly with the Annual Session Committee in Pinehurst, January 8-9, 1972.

**Adjournment.** The meeting was adjourned at 12:45 a.m.

JAMES A. HARRELL, D.D.S.  
Secretary-Treasurer

## TELEPHONE CONFERENCE CALL

November 17, 1971

**Call to Order.** At the request of the President a telephone conference call was arranged for the evening of November 17, 1971, to consider a recommendation by the Central Office Site Committee for the purchase of property for the relocation of the Central Office. The call began at 10:10 p.m.

**Roll Call.** The following participated in the conference call:

Officers: Wade H. Breeland, president; Joseph M. Johnson, president-elect; Robert H. Gainey, vice president; James A. Harrell, secretary-treasurer; Benjamin R. Baker, editor.

Committee members: William A. Current, Charles W. Horton.

Others: Walter H. Finch, Jr., chairman, Central Office Site Committee; Andrew M. Cunningham, executive secretary.

**Central Office Site Committee Report.** Dr. Walter H. Finch, Jr., chairman, Central Office Site Committee, reported that the Committee had located property at the corner of W. Hargett and St. Mary's Streets in Raleigh which the Committee recommended the Society purchase for the relocation of the Central Office. He stated that the property consisted of approximately 11,000 square feet of land and a two-story brick building with approximately 2,650 square feet of office space and off-street parking area in back of the building for 14-16 cars. He said that the building was in sound condition and that it had been paneled throughout about 2 years ago by the present owner, but that it would need some renovation and repair for efficient use by the Central Office. The owner is asking \$31,500.00 for the land and building and that \$1,000 be paid when the contract of sale is signed and the balance in 30 days.

Dr. Finch said that while the owner was anxious to sell immediately, he would prefer to continue to occupy the building for a few months and would be agreeable to leasing the property from the purchaser during that period. Dr. Finch estimated that the Society could lease the property during the interim for \$3.00 per square foot annually (\$662.50 monthly).

Mr. Cunningham reported that Mr. R. C. Howison, Jr., Society legal counsel, had advised that it would be legal for the Relief Fund to buy property as an investment and rent it to the Society or loan money to the Society to finance the purchase of property by the Society.

Mr. Howison said that to minimize tax complications he would advise that the Society borrow the money from the Relief Fund at a fair rate of interest, give the Relief Fund a first mortgage on the property, and promise to repay the principal in a reasonable length of time.

Dr. Harrell moved that the Society purchase the property recommended by the Central Office Site Committee. Dr. Current seconded the motion and it was carried.

Dr. Johnson moved that the Society borrow sufficient funds from the Relief Fund to purchase the property and to complete the necessary renovations and repair for occupancy by the Central Office. Dr. Gainey seconded the motion and it was carried.

Dr. Harrell moved that Mr. Andrew M. Cunningham be authorized to sign the contract of sale and other documents necessary to consummate the purchase of the property. Dr. Johnson seconded the motion and it was carried.

Dr. Breeland thanked Dr. Finch and the members of his committee for their efforts and their counsel.

The conference call was completed at 10:50 p.m.

JAMES A. HARRELL, D.D.S.  
Secretary-Treasurer

## RALEIGH, NORTH CAROLINA

December 5, 1971

**Call to Order.** The Executive Committee convened at Velvet Cloak Inn, Raleigh, on Sunday, December 5, 1971. Dr. Fay H. Culbreth, chairman, called the meeting to order at 2:20 p.m.

**Roll Call.** Officers present: Wade H. Breeland, president; Joseph M. Johnson, president-elect; Robert H. Gainey, vice president; James A. Harrell, secretary-treasurer.

Executive Committee members present: Fay H. Culbreth, chairman; William A. Current, W. L. Hand, Jr., Charles W. Horton.

Staff member present: Andrew M. Cunningham, executive secretary.

**Insurance Consultant.** Dr. J. S. D. Nelson, chairman, Insurance Committee, submitted a letter of intent dated November 16, 1971, from Mr. Harvey Sarner in which he agreed to complete the initial phase of his assignment as insurance consultant to the Society as outlined in his letter of May 26, 1971, for a fee of \$2,000 plus travel expenses not to exceed \$500.

Dr. Breeland moved that Mr. Sarner be employed as insurance consultant to the Society under the terms outlined in his letter of intent dated November 16, 1971. Dr. Johnson seconded the motion and it was carried.

**1972 House of Delegates.** Mr. Cunningham reported that the facilities of Hilton Inn, Raleigh, would be available April 13-15, 1972, for a meeting of the House of Delegates. However, he noted that these dates would be in conflict with the spring meeting of the N. C. Society of Dentistry for Children (April 14) and UNC Dental Alumni Day (April 15).

Mr. Cunningham was instructed to contact Hilton Inn to determine if the dates of April 16-17 were available.

President Breeland appointed the following committee to complete the plans, format, and agenda for the 1972 House of Delegates: Ralph D. Coffey, chairman; C. W. Horton and James A. Harrell.

**Dental Care Programs Committee.** Dr. Horton reported that the Dental Care Programs Committee was currently negotiating with N. C. Blue Cross and Blue Shield, Inc., for the appointment of a dentist to the company's Board of Directors and that the Committee would like to know the Executive Committee's position on the matter.

Dr. Horton also stated that the Dental Care Programs Committee had recently learned that NCBCBS was planning to provide dental coverage to elementary school children. In view of this development, the Committee felt that immediate steps should be taken to activate the N. C. Delta Dental Plans, Inc.

Dr. Harrell moved that a letter be sent to N. C. Blue Cross and Blue Shield requesting that a dentist be appointed to its Board of Directors. Dr. Gainey seconded the motion and it was carried. A copy of the letter is to be sent to Dr. William G. Ware, Jr., chairman, Dental Care Programs Committee.

Dr. Hand moved that a letter be sent to Dr. Glenn F. Bitler, president, N. C. Delta Dental Plans, Inc., emphasizing the critical need for the immediate activation of the Corporation. Dr. Harrell seconded the motion and it was carried.

**Central Office Site Committee.** Dr. Walter H. Finch, Jr., chairman, Central Office Site Committee, submitted a list of 13 proposals for relocating the Central Office. (Note: Previous to the meeting, the Committee made a site visit to 3 of them.)

Dr. Harrell moved that Dr. Culbreth and Dr. Breeland conduct a cost study of purchasing property and constructing a building. Dr. Gainey seconded the motion and it was carried.

Dr. Hand moved that the Central Office Site Committee approach the N. C. Department of Administration to seek an extension of the lease on the building now occupied by the Central Office and to find a secondary site until permanent quarters are available. Dr. Current seconded the motion and it was carried.

**Secretary-Treasurer's Report.** The Secretary-Treasurer submitted a cash flow analysis of unappropriated surplus funds and an analysis of

expenses incurred at the ADA Meeting in Atlantic City. They were received for information.

**Action Rescinded.** At the request of Dr. Breeland, Dr. Hand moved that the action taken by the Executive Committee, October 24, 1971 requesting the president to appoint a committee to devise ways and means of disseminating information to the membership be rescinded. Dr. Gainey seconded the motion and it was carried.

**Approval of Minutes.** On motion by Dr. Harrell, seconded by Dr. Hand, the minutes of October 24, 1971, and November 17, 1971 were approved.

**Commercial Exhibits.** Mr. Cunningham reported because of renovation at The Carolina a new floor plan for commercial exhibits had to be developed which included 84 booths, 7 less than in previous years. Consequently, potential revenue from the sale of exhibit space would be \$15,205, rather than \$15,380 as originally estimated.

He stated that to date 56 booths had been sold.

He also reported that because of lack of space it would be necessary to eliminate the display of scientific exhibits this year.

**Miscellaneous.** Dr. Hand moved, that if legal counsel agreed, copies of correspondence with H. F. Seawell, Jr., attorney in Carthage, be sent to the dentist involved. Dr. Horton seconded the motion and it was carried.

**Next Meetings.** The Executive Committee will hold its next meeting in Pinehurst on Saturday, January 8, 1972, at 8:30 p.m. The agenda for this meeting will include the recommendations of the District Officers Conference and a report from Dr. Hand on his expenses during his term of office as president.

The Executive Committee will meet jointly with the Annual Session Committee on Sunday, January 9, 1972, in Pinehurst to complete plans for the 116th Annual Session.

**Adjournment.** The meeting was adjourned at 4:35 p.m.

JAMES A. HARRELL, D.D.S.  
Secretary-Treasurer

## PINEHURST, NORTH CAROLINA

January 8, 1972

**Call to Order.** The Executive Committee convened at The Carolina, Pinehurst, N. C., on Saturday, January 8, 1972. Dr. Fay H. Culbreth, chairman, called the meeting to order at 8:40 p.m. and led in prayer.

**Roll Call.** Officers present: Wade H. Breeland, president; Joseph M. Johnson, president-elect; Robert H. Gainey, vice president; James A. Harrell, secretary-treasurer; Benjamin R. Baker, editor-publisher.

Executive Committee members present: Fay H. Culbreth, chairman; William A. Current, W. L. Hand, Jr., Charles W. Horton.

Staff member present: Andrew M. Cunningham, executive secretary.

**Approval of minutes.** The minutes of December 5, 1972 were approved on motion by Dr. Breeland, seconded by Dr. Harrell.

**Report of Secretary-Treasurer.** The report of the secretary-treasurer as of December 31, 1971 was received for information.

The executive secretary was requested to include in the monthly financial report the names of deceased members in whose memory donations were made to the Dental Foundation of North Carolina, Inc.

Dr. Johnson moved that the Relief Committee be requested to include in its annual report the total amount paid to relief grant recipients by the Society and by the American Dental Association. Dr. Horton seconded the motion and it was carried.

**Dental Care to Military Dependents.** Dr. Frederick G. Hasty, chairman,

Federal Dental Services Committee of the Cumberland County Dental Society, reported that the Cumberland County Dental Society was making a concerted effort through every channel possible to have the Department of Defense revoke the designation of Fort Bragg as authorized to provide dental care to military dependents under Public Law 569, and requested the N. C. Dental Society to support the Cumberland County Dental Society in its effort.

He stated that the Cumberland County Dental Society after careful research and investigation had full documentation that:

(1) Adequate civilian dental facilities are available within a 30 mile radius of Fort Bragg; and

(2) Military dependents in the area suffer because of a lack of continuity of dental diagnosis and treatment.

Dr. Gainey moved that the president write a letter to the Department of Defense in support of the Cumberland County Dental Society's effort to have revoked the designation of Fort Bragg as authorized to provide dental care to military dependents. Dr. Johnson seconded the motion and it was carried. The Cumberland County Dental Society was requested to draft the letter for the Executive Committee's approval. A copy of the letter is to be sent to the Fifth District Trustee.

**1972 House of Delegates.** Mr. Cunningham reported that he had tentatively reserved the facilities of Hilton Inn, Raleigh, for the convening of the 1972 House of Delegates April 16-17, 1972.

Dr. Hand moved that the 1972 House of Delegates be convened at Hilton Inn, Raleigh, April 16-17, 1972. Dr. Breeland seconded the motion and it was carried.

**Cost Study of Proposed Central Office Building.** Dr. Culbreth reported that he had determined that a loan of 75 percent of the appraised value of the land and the proposed building could probably be secured at not more than 8 percent interest. Mr. Cunningham was requested to submit to Dr. Culbreth the floor plan of the present Central Office building with suggested modifications to better meet the future needs of the Central Office. Dr. Culbreth stated he needed this information to complete the cost study.

**Grievance Procedures.** It was noted that the *Bylaws*, Article II, Section 2, Professional Relations Committee, provided that the Committee "set up rules and procedures for arbitration or adjudication of complaints."

The Executive Secretary was directed to request the chairman of the Professional Relations Committee to submit this information to the Central Office and that it be published and distributed to the membership.

**Recommendations of D.O.C.** The recommendations of the 19th Annual District Officers Conference, December 4-5, 1971 were reviewed and discussed. The list of the 17 recommendations of the Conference is attached. Action on each of the recommendations follow.

Recommendation 1. Referred to the chairman of the State Constitution and Bylaws Committee and the chairmen of the District Constitution and Bylaws Committees on motion by Dr. Hand, seconded by Dr. Current.

Recommendation 2. Referred to the District presidents on motion by Dr. Hand, seconded by Dr. Current.

Recommendation 3. To be submitted to the House of Delegates for consideration and action by an individual designated by the president on motion by Dr. Hand, seconded by Dr. Gainey.

Recommendation 4. Referred to the Continuing Education Committee on motion by Dr. Hand, seconded by Dr. Horton.

Recommendation 5. Referred to the Dental Practice Act Committee on motion by Dr. Hand, seconded by Dr. Johnson.

Consideration of the remaining recommendations was postponed until the next meeting, January 9.

**Adjournment.** The meeting was adjourned at 11:05 p.m.

JAMES A. HARRELL, D.D.S.  
Secretary-Treasurer

**PRINCIPAL ACTIONS AND RECOMMENDATIONS  
OF  
19TH ANNUAL DISTRICT OFFICERS CONFERENCE**

**December 4-5, 1971**

1. The Conference went on record in favor of continuing the study of District Constitution and Bylaws to the end that a complete revision of the Constitution and Bylaws be presented for consideration at the District Meetings in the Fall of 1972.

2. The Conference agreed that District Presidents provide a place on their 1972 programs for a representative of the Industrial Commission to explain their program.

3. The Conference recommended that an individual be appointed to address the Society at its annual meeting in Pinehurst prior to election of officers on establishing a new tradition by electing a secretary-treasurer on a district rotation basis annually. In succeeding years he would be a candidate for the office of vice president, president-elect and then president.

4. The Conference recommended that an appropriate committee of the North Carolina Dental Society explore a meaningful requirement for at least a minimal continuing education program.

5. The Conference recommended that the Dental Practice Act Committee propose a change in the dental laws to have the terms of appointed members of the State Board of Dental Examiners expire at the next official election date.

6. The Conference recommended that the Dental Practice Act Committee seek appropriate action to assure that dentists will be notified of deadline dates for election of members of the Board of Dental Examiners.

7. The Conference recommended that District vice presidents conduct a vigorous, continuing campaign for new members and that District secretaries notify new members that they are expected to be present for induction at the next annual meeting.

8. The Conference went on record recommending that upon receiving an application for membership the secretary-treasurer contact the candidate by telephone and explain the procedure for election to membership.

9. The Conference approved a recommendation that outgoing District presidents be awarded an appropriate plaque in recognition of their service of leadership.

10. The Conference agreed that in future years District Public Relations Chairmen be invited to meet with the District editors at the District Officers Conference.

11. The Conference approved in principle the development of manuals for the delegates to the NCDS House of Delegates and delegates to the ADA House of Delegates.

12. The Conference recommended that a mechanism be developed to permit elected student representatives of each class at the UNC School of Dentistry to be seated in the NCDS House of Delegates without vote but with the privilege of the floor.

13. The Conference recommended that a mechanism be developed to promote liaison with legislators at the State and National levels.

14. The Conference approved the creation of an inter-agency committee composed of representatives of the Society, the school of dentistry and the Board of Dental Examiners to discuss issues challenging dentistry and report to the District Officers Conference and the House of Delegates.

15. The Conference approved a draft of amendments to the General Statutes to provide for specialty licensure with the understanding that the Board include in its rules and regulations definition of "announcement of limitation of practice" and "holding himself out to the public, etc."

16. The Conference recommended that the amendments to the General Statutes to provide for specialty licensure as approved by the Conference be submitted to the 1972 House of Delegates for its consideration by the Dental Practice Act Committee.

17. The Conference recommended that the program proposed by the N. C. Delta Dental Plans, Inc., and the participating agreement be reviewed to the end that both might be improved and made more acceptable to the profession.

## PINEHURST, NORTH CAROLINA

January 9, 1972

**Call to Order.** The Executive Committee convened in joint session with the Annual Session Committee at The Carolina, Pinehurst, N. C., Sunday, January 9, 1972. President Wade H. Breeland called the meeting to order at 9:40 a.m. Dr. James A. Harrell led in prayer.

**Roll Call.** Officers present: Wade H. Breeland, president; Joseph M. Johnson, president-elect; Robert H. Gainey, vice president; James A. Harrell, secretary-treasurer; Benjamin R. Baker, editor-publisher.

Executive Committee members present: Fay H. Culbreth, chairman; William A. Current, W. L. Hand, Jr., Charles W. Horton.

Annual Session Committee members present: M. L. Cherry, general chairman; Darden Eure, Jr., arrangements; Donald D. Culp, entertainment.

Staff member present: Andrew M. Cunningham, executive secretary.

**Report of Annual Session Committee.** Dr. Breeland introduced Dr. M. L. Cherry, general chairman, Annual Sessions Committee, who presented the report of the Annual Session Committee and a budget request of \$11,605.00 for the 116th annual session. It was noted that this was \$105.00 over the \$11,500.00 allocated in the 1971-72 budget approved by the Executive Committee July 10, 1971.

Dr. Breeland thanked Dr. Cherry and the members of his committee for their excellent reports.

Dr. Culbreth assumed the chair and declared the Executive Committee in executive session.

## EXECUTIVE SESSION

**Approval of Annual Session Budget.** On motion by Dr. Harrell, seconded by Dr. Breeland, the reports and budget request of the Annual Session Committee totalling \$11,605.00 was approved and \$105.00 was allocated from the Contingent Fund to the Annual Session Committee. A copy of the 1972 Annual Session Budget is attached to these minutes.

**Delta Dental Plans of N. C.** Dr. Glenn F. Bitler, president, Delta Dental Plans of N. C., Inc., reported that the Corporation now had 550 participating dentists, 350 short of the 900 required by the Commissioner of Insurance for licensing the Corporation to accept contracts. He stated that to date solicitation by mail and appearances of members of the Board of Directors at local dental society meetings had failed to get the required number of participating dentists. He suggested that an organized person-to-person campaign in communities throughout the state might produce the desired results.

Dr. Harrell moved that Dr. Bitler be authorized to organize and conduct a person-to-person campaign for participating dentists in Delta Dental Plans of N. C., Inc., and that Dr. Bitler be reimbursed by the Society for all out-of-pocket expenses incurred in conducting the campaign, including telephone calls. Dr. Horton seconded the motion and it was carried.

Dr. Bitler was requested to furnish a list of participating dentists to members of the Executive Committee for information.

**Recommendations of D.O.C.** The Committee continued its review and discussion of the recommendations of the 19th Annual District Officers Conference, December 4-5, 1972. Actions on the recommendations follow.

Recommendation 6. Approved on motion by Dr. Hand, seconded by Dr. Harrell.

Recommendation 7. Referred to District officers on motion by Dr. Breeland, seconded by Dr. Johnson.

Recommendation 8. Referred to District secretary-treasurers on motion by Dr. Hand, seconded by Dr. Breeland.

Recommendation 9. Referred to District Officers, on motion by Dr. Breeland, seconded by Dr. Gainey.

Recommendation 10. Referred to the president of the District Officers Conference, on motion by Dr. Horton, seconded by Dr. Breeland.

Recommendation 11. Approved on motion by Dr. Breeland, seconded by Dr. Johnson.

Recommendation 12. Approved on motion by Dr. Breeland, seconded by Dr. Harrell.

Recommendation 13. Approved by the Executive Committee October 24, 1971.

Recommendation 14. Amended to read: "The Conference approved the creation of an inter-agency committee composed of representatives of the Society, the school of dentistry, the Board of Dental Examiners and other appropriate agencies and associations to discuss issues challenging dentistry and report to the District Officers Conference and the House of Delegates." The recommendation as amended was approved on motion by Dr. Hand, seconded by Dr. Harrell.

Recommendation 15. Approved and referred to Dental Practice Act Committee on motion by Dr. Hand, seconded by Dr. Johnson.

Recommendation 16. Approved and referred to Dental Practice Act Committee on motion by Dr. Hand, seconded by Dr. Johnson.

Recommendation 17. Approved and referred to Delta Dental Plans of N. C. on motion by Dr. Hand, seconded by Dr. Gainey.

**Membership Report.** The executive secretary reported that as of December 31, 1971 active and life members of the Society totalled 1,533 a net gain of 44 since December 31, 1970. He stated that during the calendar year 1971 the Society accepted 90 new members (85 at the Fall meetings of the Districts and 5 since then) and lost 46 members.

A breakdown of the losses follow:

Resigned .....	7
Deceased .....	22
Dropped from roll.....	5
Moved out-of-state .....	5
Retired .....	7
	<hr/>
	46
	<hr/>

The report was received for information.

**ADPAC.** Consideration of organizing a chapter of American Dentists for Political Action in North Carolina was postponed until the next meeting on motion by Dr. Breeland, seconded by Dr. Gainey.

**President's Expenses.** At the request of the Executive Committee, Dr. W. L. Hand, Jr., immediate past president, submitted a report on his personal expenses during his term of office. He stated that:

(1) He traveled 7,445 miles, exclusive of attendance at the ADA meeting, the State meeting, and the ADA regional conference in Atlanta;

(2) Sent out 553 letters from his office; and

(3) His out-of-pocket expenses, exclusive of stenographic services and mileage, totalled approximately \$2,000.00.

It was noted that the above expenses did not include the cost of time spent out of his office in the performance of his duties as president.

The report was received for information.

**Duties of Central Office.** Dr. Gainey moved that the Central Office Planning Committee be requested to consider the necessary manpower needed to permit the Central Office to assume more responsibility for the correspondence and functions of the Society. Dr. Current seconded the motion and it was carried.

**Exhibitor Complaint.** A letter was received from an exhibitor complaining that booths at the annual meeting are sold to mail order houses and requesting that this policy be abolished. On motion by Dr. Breeland, seconded by Dr. Harrell, the letter was referred to the chairman of the Exhibits Committee for reply in the negative.

**Seminar on Dental Laboratory Licensure.** It was noted that the ADA Council on Dental Laboratory Relations would hold a seminar on dental laboratory and technician licensure in Chicago April 12-13. On motion by Dr. Harrell, seconded by Dr. Breeland, the president was authorized to send a representative from the Society to the seminar.

On motion by Dr. Breeland, seconded by Dr. Gainey, resolution 209 adopted by the 1971 ADA House of Delegates was referred to the Dental Laboratory Relations Committee for study and recommendations. The text of resolution 209 follows.

**209. Resolved,** that constituent and component dental societies be urged to conduct studies in conjunction with appropriate laboratory groups, based upon the Battelle Memorial Institute Research Report, *A Study of the Potentialities of Modern Technology in the Dental Laboratory Industry* and the *Reports and Recommendations of the General Battelle Study Conference*, and be it further

**Resolved,** that recommendations from such studies be implemented where appropriate to meet the needs of the particular area, and be it further

**Resolved,** that recommendations developing from such conferences on the subject of registration or licensure of dental laboratories or dental technicians be forwarded to the Council on Dental Laboratory Relations for consideration during its forthcoming seminar on licensure or registration of dental laboratories and dental laboratory technicians.

**Conference of Dental Examiners and Dental Educators.** On motion by Dr. Johnson, seconded by Dr. Harrell, the president was authorized to designate a representative from the Society to attend the Conference of Dental Examiners and Dental Educators at ADA headquarters, February 11-12, 1972 or to attend the Conference himself if he so desires.

**Provisional Licensees and Interns.** The question of whether dentists holding provisional licenses or intern permits were eligible for membership in the Society was discussed. The question was referred to the Constitution and Bylaws Committee for study and recommendations to the House of Delegates on motion by Dr. Breeland, seconded by Dr. Hand.

**Purchase of Stock in DSPIC.** It was noted that the 1971 House of Delegates allocated \$5,000.00 of surplus funds for the purchase of stock in Dental Service Plans Insurance Company. The executive secretary was directed to secure from Dr. Roy L. Lindahl and other appropriate sources, information on the company, including its organization and purpose for distribution to the Executive Committee, on motion by Dr. Current, seconded by Dr. Harrell.

**Department of Human Resources.** Dr. Breeland called the Committee's attention to the appointment of Dr. Lenox D. Baker as secretary of the Department of Human Resources. This new department created by the 1971 Legislative Act to reorganize state government places some 30 commissions and divisions under Dr. Baker's jurisdiction, including the State Board of Health, Department of Mental Health, Department of Social Services, the Blind Commission and the Medical Care Commission.

Dr. Breeland stated that he had been informed that no drastic changes in the agencies under Dr. Baker's control was anticipated at present. However, he warned that the Society should keep a close watch on any developments which would affect the status of dentistry, and particularly the Dental Health Division.

**Resignation of Financial Secretary.** Mr. Cunningham announced that

Mrs. Kathryn P. Montague of the Central Office staff had submitted her resignation effective January 31, 1972. Mrs. Montague has served capably, efficiently, and loyally as Financial Secretary since October 1968 and Mr. Cunningham said that finding someone to replace her would be a very difficult task. Mrs. Montague resigned because she felt she must stay at home and assume full responsibility for the care and raising of her children.

**Next Meeting.** It was agreed that the next meeting of the Executive Committee would be held at the Central Office on March 5, 1972 at 10:00 a.m.

**Adjournment.** The meeting was adjourned at 12:55 p.m.

JAMES A. HARRELL, D.D.S.  
Secretary-Treasurer

### 1972 ANNUAL SESSION BUDGET

Approved by Executive Committee, January 9, 1972

Arrangements .....	\$ 3,310.00
Auxiliary .....	—0—
Projected Clinics .....	—0—
Table Clinics .....	130.00
Entertainment .....	
Banquet .....	\$ 70.00
Dance .....	285.00
Entertainment .....	900.00
Social Hour (Sun.) .....	500.00
Reception (Tues.) .....	700.00
	<hr/> 2,455.00
Exhibits (Commercial) .....	1,825.00
Monitor .....	—0—
Program .....	3,000.00
Publicity .....	295.00
Sports .....	—0—
Hospitality .....	30.00
House of Delegates .....	525.00
Necrology .....	35.00
	<hr/> <hr/> \$11,605.00

### RALEIGH, NORTH CAROLINA

March 12, 1972

**Call to Order.** The Executive Committee convened at the Central Office, Raleigh, N. C., on Sunday, March 12, 1972. Dr. Fay H. Culbreth, chairman, called the meeting to order at 10:15 a.m., and led in prayer.

**Roll Call.** Officers present: Wade H. Breeland, president; Joseph M. Johnson, president-elect; Robert H. Gainey, vice president; James A. Harrell, secretary-treasurer.

Executive Committee present: Fay H. Culbreth, chairman; William A. Current, Charles W. Horton.

Staff member present: Andrew M. Cunningham, executive secretary.

**Approval of Minutes.** The minutes of January 8 and 9, 1972, were approved on motion by Dr. Harrell, seconded by Dr. Horton.

**N. C. Delta Dental Plans.** Dr. Glenn F. Bitler, president, N. C. Delta Dental Plans, Inc., reported that as of March 9, 1972, 621 dentists had signed participating agreements which represented an increase of 88 since the member-to-member campaign was launched at the meeting in Raleigh, February 6, 1972. He estimated that within 2 to 3 months the Corporation would have enrolled over 800 dentists in the plan which might satisfy the Insurance Commissioner for licensing purposes.

He pointed out that the next step would be to employ an executive director whose qualifications would meet the approval of the Insurance Commissioner.

Finally, he stated that a fee survey of participating dentists would be conducted at the earliest feasible date in order to develop actuarial data.

On motion by Dr. Harrell, seconded by Dr. Horton, the Executive Committee extended its sincere thanks and appreciation to Dr. Bitler for his leadership and dedicated efforts in the development of the N. C. Delta Dental Plans.

Dr. Bitler explained in detail the purpose and functions of the Dental Service Plans Insurance Co. He stated that the Company was organized to underwrite multistate Delta contracts in states without active Delta plans. He urged the Executive Committee to purchase \$5,000 stock in Dental Service Insurance Plans Co., as authorized by the 1971 House of Delegates.

**Purchase of DSPIC Stock.** Dr. Johnson moved that the Society purchase \$5,000 Dental Service Plans Insurance Co. stock as authorized by the 1971 House of Delegates. Dr. Current seconded the motion and it was carried.

**Report of Secretary-Treasurer.** The report of the Secretary-Treasurer, dated February 29, 1972, was received for information on motion by Dr. Breeland, seconded by Dr. Horton.

**Relocation of Central Office.** Dr. Culbreth reported that at the request of the Executive Committee he had completed a cost and feasibility study of the Society purchasing property and constructing its own Central Office building for occupancy when the lease on the building with the State of North Carolina presently occupied by the Central Office expired August 31, 1972.

He stated that reputable financial institutions and the Society's CPA both agreed that since the Society is a non-profit organization that it would be inadvisable for the Society to consider building its own building for several reasons.

1. Depreciation would not be a tax advantage since the Society enjoyed tax-exempt status.

2. Appreciation could not be considered a favorable factor because of additional costs related to moving to and occupying a building owned by the Society, i.e., interest on borrowed funds, new furnishings, insurance, taxes, maintenance, and utilities, not to mention the cost of someone's time to keep records, supervise the operation of the building, and perform other duties related to ownership.

3. IRS would most likely look with disfavor if such a building were constructed for future sale, since the Society is a "non-profit" organization.

4. An investment in a building would eliminate a great deal of the flexibility that the Society now has concerning its unappropriated surplus.

5. The Society can now earn from 5 percent to 6 percent on excess funds and it would be difficult to predict that this rate of return on invested funds could be improved upon by putting the same money, or possibly more, into real estate.

Dr. Culbreth further pointed out that the State of North Carolina had refused to renew the lease on the property now occupied by the Central Office beyond the expiration date of August 31, 1972, and this would not allow sufficient time for the Society to acquire property and build.

Based on the above reasons, Dr. Culbreth said that he had concluded that the Society should not build its own building but continue on its present course of leasing office space.

Mr. Cunningham presented proposals from two companies offering to lease office space to the Society for the consideration of the Executive Committee.

Dr. Current moved that a 3-year lease be negotiated with T. W. Smith and Co. for adequate office space in Meredith Woods Professional

Building, 2310 Myron Drive, Raleigh, with an option to sub-lease and renew, and that in the meantime an effort be made to find an investor who would be willing to build a building to meet the requirements of the Society and lease to the Society on a 10-year basis. Dr. Harrell seconded the motion and it was carried.

**ADPAC.** Dr. Johnson moved that the Society authorize the organization of a chapter of American Dental Political Action Committee in North Carolina; that a resolution to this effect be submitted to the House of Delegates; and that the executive director of ADPAC be invited to speak to the House of Delegates; provided he would be willing to attend to his own expense. Dr. Current seconded the motion and it was carried.

**NCDA Diet Manual.** Dr. Current moved that the Society endorse the first edition of the *N. C. Dietetic Association, Inc., Diet Manual*. Dr. Harrell seconded the motion and it was carried. It was noted that a section on a modified dental diet was included in the manual and that it had been reviewed by Dr. George Dudley, a staff member of the Dental Health Division. Dr. Dudley recommended endorsement of the publication by the Society.

**Resignation of Editor-Publisher.** By letter, Dr. Benjamin R. Baker, editor-publisher for the past several years, submitted his resignation from this office effective with the August, 1972 issue of *The Journal*. Dr. Gainey moved that Dr. Baker's resignation be accepted with regret and with sincere thanks and appreciation for the fine service Dr. Baker had rendered the Society during his tenure of office and for the excellent suggestions contained in his letter of resignation which would be Baker's successor. Dr. Johnson seconded the motion and it was carried.

**Honorary Membership.** Dr. Breeland moved that Dr. Louis A. Saporito of Newark, N. J., president-elect of the American Dental Association and Dr. John M. Faust of Hattiesburg, Miss., Fifth District Trustee of the American Dental Association, be recommended to the House of Delegates for election to honorary membership in the Society. Dr. Harrell seconded the motion and it was carried.

**Dental Practice Act Committee.** Proposed amendments to the dental laws of North Carolina relating to specialty licensure were submitted by Dr. Fay H. Culbreth, chairman, Dental Practice Act Committee. Dr. Culbreth stated that the amendments had been suggested and approved by the District Officers Conference which served as a workshop on proposed specialty legislation. He said that the amendments had the verbal approval of the president of the State Board of Dental Examiners and that the UNC School of Dentistry administration had supported the specialty law in the past. Dr. Horton moved that the amendments be approved by the Executive Committee. Dr. Johnson seconded the motion and it was carried. Drs. Gainey and Breeland requested that they be recorded as voting against the motion.

**Honoring Dr. Paul E. Jones.** Dr. Breeland moved that Dr. Paul E. Jones of Farmville be given special recognition at the annual session in Pinehurst for his long and outstanding service to dentistry in North Carolina. Dr. Harrell seconded the motion and it was carried.

**Medicaid.** It was noted that dental services to Medicaid recipients in North Carolina had been drastically curtailed by the 1971 General Assembly effective August 1, 1971. Dr. Horton moved that the Dental Care Programs Committee prepare and submit to the House of Delegates a resolution strongly protesting the curtailment of dental services to Medicaid recipients and urging that a comprehensive dental care program be restored under the Medicaid program. Dr. Johnson seconded the motion and it was carried.

**Next Meeting.** It was agreed that the next meeting of the Executive

Committee would be held at Hilton Inn, Raleigh, Saturday, April 15 at 8:00 p.m.

**Adjournment.** The meeting was adjourned at 1:40 p.m.

JAMES A. HARRELL, D.D.S.  
Secretary-Treasurer

## RALEIGH, NORTH CAROLINA

April 15, 1972

**Call to Order.** The Executive Committee convened at Hilton Inn, Raleigh, N. C., Saturday, April 15, 1972. Dr. Fay H. Culbreth, chairman, called the meeting to order at 8:30 p.m. Dr. Harrell led in prayer.

**Roll Call.** Officers present: Wade H. Breeland, president; Joseph M. Johnson, president-elect; Robert H. Gainey, vice president; James A. Harrell, secretary-treasurer; Benjamin R. Baker, editor-publisher.

Executive Committee members present: Fay H. Culbreth, chairman; William A. Current, Charles W. Horton, W. L. Hand, Jr.

Staff member present: Andrew M. Cunningham, executive secretary.

Others present: Ralph D. Coffey, speaker-of-the-house; Colin P. Osborne, past president.

**Approval of Minutes.** The minutes of March 12, 1972 were approved on motion by Dr. Johnson, seconded by Dr. Harrell.

**Report of Secretary-Treasurer.** The report of the secretary-treasurer as of March 31, 1972 was received for information on motion by Dr. Harrell, seconded by Dr. Gainey.

**Reports and Resolutions.** The Committee reviewed and discussed the reports and resolutions submitted to the House of Delegates.

**Commendation to Fifth District Trustee.** Dr. Harrell moved that a letter of commendation and appreciation be sent to Dr. John M. Faust, Fifth District Trustee, American Dental Association, for the recent report he submitted on the March meeting of the ADA Board of Trustees to delegates, alternates and officers of the constituent societies in the Fifth District. Dr. Breeland seconded the motion and it was carried.

**Adjournment.** The meeting was adjourned at 10:30 p.m.

JAMES A. HARRELL, D.D.S.  
Secretary-Treasurer

# Committee Reports

STANDING AND SPECIAL  
(In alphabetical order)

## ANNUAL SESSION COMMITTEE

*General Chairman*—M. L. CHERRY

DARDEN J. EURE, JR.

OTIS F. HENDREN

DONALD D. CULP

ROBERT B. LITTON

L. P. MEGGINSON, JR.

**Meetings.** The Annual Session Committee met January 8, 1972. On January 9, 1972 the Committee met jointly with the Executive Committee. Both meetings were held at The Carolina in Pinehurst.

**Budget.** A total budget of \$11,605.00 for the 1972 Annual Session was approved by the Executive Committee on January 9, 1972.

**Arrangements.** This committee has completed arrangements in cooperation with the Central Office for the Annual Session including: housing, assignment of meeting rooms, properties for essayists, employment of a stenotypist, registration, presentations, and printing of hand programs. An appropriation of \$3,310.00 has been approved. Dr. Darden J. Eure, Jr., is chairman.

**Projected Clinics.** Seven projected clinics will be presented on Wednesday, May 17 at 9:30 a.m. No appropriation was requested. Dr. James A. Privette is chairman.

**Table Clinics.** Twenty-one table clinics will be presented on Sunday, May 14, at 3:00 p.m. An appropriation of \$130.00 has been approved. Dr. Wilburn A. Davis is chairman.

**Commercial Exhibits.** Because of extensive remodeling at The Carolina which precluded the display of commercial exhibits a new floor plan was designed to accommodate 84 exhibit spaces. In previous years the floor plan included 91 booths.

All 84 booths have been sold which will yield \$15,215.00 in revenue. An appropriation of \$1,850.00 has been approved. Dr. E. A. Pearson, Jr., is chairman.

**Entertainment.** The total allocation to the Entertainment Committee is \$2,455.00 as follows:

Banquet .....	\$ 70.00
Dance .....	285.00
Entertainment .....	900.00
Social Hour (Sunday) .....	500.00
Reception (Tuesday) .....	700.00
	<hr/>
	\$2,455.00

Dr. Robert B. Litton is in charge of the annual banquet to be held Tuesday, May 16 at 7:00 p.m.

Dr. Donald D. Culp is in charge of the social hour on Sunday, May 14

at 5:30 p.m.; the reception on Tuesday, May 16, at 5:30 p.m.; the entertainment and dance on Tuesday, May 16 beginning at 8:30 p.m.

**Monitor.** Monitors will be assigned to all scientific sessions and general sessions. No appropriation was requested. Dr. Otis F. Hendren is chairman.

**Program.** Three nationally known clinicians have been invited for the scientific program. They are: Dr. Ralph W. Phillips, Indianapolis; Dr. M. L. Butterworth, Jr., Plantation, Florida; and Dr. Robert P. McGraw, Independence, Missouri.

An appropriation of \$3,000.00 for the scientific program has been approved. Dr. William A. Mynatt is chairman.

**Publicity.** A professional journalist has been employed to prepare pre-convention publicity and to release stories to the wire services from Pinehurst during the meeting. An appropriation of \$295.00 has been approved.

**Sports.** The annual N.C.D.S. Golf Tournament will be held at the Pinehurst Country Club on Sunday, May 14. Entrance fees are expected to cover the cost of operating the Tournament and no appropriation was requested. Dr. John H. Dixon is chairman.

**Scientific Exhibits.** There will be no scientific exhibits on display during the 1972 Annual Session because of lack of appropriate space due to the renovations underway at The Carolina.

**House of Delegates.** An appropriation of \$525.00 has been approved for the House of Delegates which will convene April 16-17 at Hilton Inn, Raleigh. This will cover preparation, publication and mailing of the Blue Book, the services of a stenotypist, a social hour and other miscellaneous items incidental to the operation of the House of Delegates.

### Resolutions

This report is informational in nature and no resolutions are submitted.

## CONSTITUTION AND BYLAWS COMMITTEE

CHARLES A. REAP, JR. (1974), *chairman*

G. SHUFORD ABERNETHY (1973)

J. HENRY LIGON, JR. (1972)

THOMAS G. NISBET (1975)

C. P. GODWIN (1976)

**Meetings:** No formal meetings were held. Transactions were via telephone during February, 1972.

**Assignment:** At its meeting January 9, the Executive Committee discussed the question of whether dentists holding provisional licenses under G. S. 90-29.3, or intern permits under G. S. 90-29.4 were eligible for membership in the Society. The question was referred by the Executive Committee to the Constitution and Bylaws Committee for study and recommendation to the House of Delegates.

**Action:** By telephone, each member of the Constitution and Bylaws Committee agreed that dentists who are provisionally licensed or dentists who are holders of intern permits should not be considered eligible for membership in the Society.

### Resolutions

**15. Resolved,** that it be the policy of the North Carolina Dental Society to consider ineligible for membership dentists who hold provisional licenses under G.S. 90-29.3 and dentists who hold intern permits under G.S. 90-29.4, unless they otherwise meet the qualifications for membership as provided in Article III-Membership, Section 2, of the *Constitution*.

**DENTAL CARE PROGRAMS COMMITTEE**WILLIAM G. WARE, JR., *chairman*

EDWARD U. AUSTIN

T. S. FLEMING

JOSEPH E. CAMPBELL

CHARLES W. HORTON

GEORGE D. DUDNEY

JAMES B. HOWELL

FRANKLIN E. MARTIN

**Meetings.** The committee has met monthly with representatives of the Blue Cross and Blue Shield organization and the Department of Social Services.

**Assignments.** The committee has been asked to consider and present to Blue Cross and Blue Shield and the Department of Social Services the following:

1. Restructuring and redirecting the scope of dental coverage of the Title XIX Program in response to limitations placed on the program on August 1, 1971.

2. Development and publication of an appropriate manual for distribution to North Carolina dentists superceding prior manuals and reflecting limitations of the Title XIX Program.

3. Discussion with the Fiscal Intermediary to determine if guidelines developed by the Peer Review Committee and approved by the Executive Committee would be a viable document in review of cases referred to the Peer Review Committee by the Intermediary.

**Results of Consideration.**

**Manual.** Procedures allowable under the limited Medicaid Program have been clarified, coded and placed in a manual which was mailed to North Carolina dentists in February, 1972.

**Guidelines.** Representatives of the Fiscal Intermediary state that the Society's Guidelines for Review is a document that is adequate for cases requiring review procedures.

**Board Representation on Blue Cross and Blue Shield.** The committee has requested the President of North Carolina Blue Cross and Blue Shield to introduce to the Board of the Corporation the interest of the North Carolina Dental Society in having board representation for dentistry. The President of the Corporation reports some progress along these lines, but so far has offered nothing substantive.

**Resolutions**

This report is informational in nature and no resolutions are submitted.

**DENTAL CARE PROGRAMS COMMITTEE****Supplemental Report Number 1**

When the Title XIX (Medicaid) program was put into effect in North Carolina, a relatively comprehensive dental program was provided for eligible recipients. Fees paid the provider were calculated at the 75th percentile. The law provides that fees payable to providers be raised in accordance with the increase in cost of living index not including the medical cost index.

The Title XIX program was reduced in scope by the North Carolina General Assembly on August 1, 1971. Drastically reduced were dental services. Providers are now paid 90 percent of the 75th percentile. Spokesmen from the Department of Social Services inform us that no increase in payments to providers has been accomplished. The worst result is that Medicaid patients are being denied dental treatment that formerly was available to them. They are denied treatment that they can ill afford. Therefore, the following resolution is submitted.

### Resolutions

23. **Resolved**, that the North Carolina Dental Society strongly urge the North Carolina General Assembly to reinstate the Title XIX (Medicaid) program insofar as the dental program is concerned to its original status prior to August 1, 1971 subject to the following restrictions:

1. All diagnostic, restorative and prophylactic treatment be completed for a patient prior to fabrication of removable partial dentures.

2. Prior approval of the North Carolina Department of Social Services before fabrication of complete or partial dentures.

### DENTAL CARE PROGRAMS COMMITTEE

#### Subcommittee on State Agencies

WALTER H. FINCH, JR., *chairman*

ROBERT H. BENFIELD  
CLEVELAND W. FLOYD

NICHOLAS J. BARTIS  
M. W. ALDRIDGE

**Meetings.** The Committee held no meetings.

**Assignments.** The 1971 House of Delegates adopted the following resolution (*Trans.* 1971, Page 72, 16-1971-H)

**Resolved**, that the Dental Care Programs Committee be requested to review the 1967 State Agencies Dental Fee Schedule, and negotiate with appropriate state agency for a revision of fees equal to or greater than the level of those fees established by the State Industrial Commission Fee Schedule.

President Breeland directed that this committee study the delivery of dental care for inmates of the State Schools of Juvenile Correction.

**Results of Study.** On October 29, 1971 a letter from the Chairman was sent to Mr. Andrew Jones, State Budget Officer, requesting an appointment to discuss the matter set forth in the above resolution. No reply was received. Subsequently, Mr. Frank R. Justice was appointed to succeed Mr. Jones as State Budget Officer. On January 31, 1972, a similar request was directed to Mr. Justice. No reply has yet been received. We would like to suggest that the new committee be directed to continue with this same assignment.

Regarding the second assignment, this committee found that the appropriated budget for dental care for the inmates of schools of the N. C. Department of Juvenile Correction (now the Department of Youth Development) appeared to be both inadequate and inequitable. Mr. R. Vance Robertson, Acting Commissioner of Youth Development, realizing this, is planning to request sufficient funds for the next biennium to provide adequate and systematic care for these children. If funded, this system will receive administrative assistance from the Department of Dental Health of the State Board of Health.

### Resolutions

10. **Resolved**, that the North Carolina Dental Society approve a plan for dental care for the inmates of the schools of the North Carolina Department of Youth Development, which will be a cooperative effort of that Department and the Department of Dental Health of the State Board of Health.

**DENTAL CARE PROGRAMS COMMITTEE****Subcommittee on Peer Review**JAMES B. HOWELL, *chairman*

GLENN F. BITLER

DAVID H. FRESHWATER

JOSEPH D. CAMPBELL

FLEMING H. STONE

FRANKLIN E. MARTIN

WILLIAM G. SNYDER

D. F. HORD

JULIAN R. ROGERS

FRANKLIN D. BELL

HAROLD E. PLASTER

**Meetings.** Just prior to the end of the fiscal year in the 1971 meeting in Pinehurst this Committee reached a stalemate on review procedures with Blue Cross and Blue Shield. It was decided to arbitrate these differences with the Blues through the Dental Care Programs Committee, which is the parent committee. The Chairman of the Peer Review Committee met in these sessions as a member of the parent committee.

It is believed that a satisfactory understanding has been reached concerning Peer Review during these meetings with the Blue Cross and Blue Shield representatives.

The State Peer Review Committee met in Review Session on March 1, 1972. At this time an appeal from a district review committee was heard and acted upon. An adjustment of fees which was favorable to the patient and the dentist was recommended by this committee and was accepted by the insurance representatives.

There were two members of the Health Insurance Council of North Carolina present at this meeting. They were most cooperative and went to great measures to help familiarize us with their policies and procedures and assured us of their support in our review activities. These gentlemen were very helpful to members of this committee by explaining their programs and how we could best assist them in their management.

Another meeting of the State Peer Review Committee has been set for April 6, 1972, in conjunction with the Dental Care Programs Committee. At these meetings representatives of the National and North Carolina Health Insurance Council will again be present.

**Assignment.** Revisions of the Guidelines and procedures of this committee in line with the requirements of present day review procedures.

**Results of Study.** After several meetings with the representatives of the Health Insurance Council, both State and National, and with the representatives of Blue Shield and Blue Cross, this committee has achieved a new enlightenment relative to what is necessary for review procedures. Emphasis has been given to the necessity of including quality and utilization control in the realm of peer review activities. This addition of duties is in line with recommendation from the Dental Care Programs Council of the American Dental Association and the Executive Committee of N.C.D.S.

Certain additions and revisions to the Guidelines have been completed. Other information of an explanatory nature has been compiled. It is anticipated that this material will be assembled to fit in a loose-leaf type of manual which may be continually updated.

Other recommendations and resolutions shall be made to the House of Delegates which will facilitate the duties of this committee.

**Resolutions**

This report is informational in nature and no resolutions are submitted.

**DENTAL CARE PROGRAMS COMMITTEE****Subcommittee on Peer Review  
Supplemental Report Number 1**

In order to clarify certain policies important to Peer Review procedures the following resolutions are proposed:

**Resolutions**

**24. Resolved**, that the existence of dental coverage through any pre-payment mechanism should not be a factor in a dentist's determination of his fees, and be it further

**Resolved**, that a dentist charging in excess of his usual and customary fees, by reason of a patient's eligibility under a dental care plan, shall be considered to be in violation of the North Carolina Dental Society's Code of Ethics, and be it further

**Resolved**, that its members adopt the policy of not charging patients for the completion of the uniform claim form, but may make a charge for any non-uniform claim form or for any additional forms which must be completed, and be it further

**Resolved**, that the attending dentist's statement, otherwise known as the uniform claim forms, and which has been approved by the H.I.C., and the A.D.A. Council on Dental Care Programs, be approved and recommended for routine use by the N.C.D.S. and be it further

**Resolved**, that it is the duty of a member to abide by the decisions of the Review Committee duly constituted by the North Carolina Dental Society pursuant to policies and guidelines for such Review Committee approved by the House of Delegates or Board of Directors of this Association and to comply with the reasonable requirements of such committee to perform its functions. Any violation of such duty constitutes unethical conduct.

**25. Resolved**, that the Peer Review Committee be directed to compile a manual of guidelines for Peer Review mechanism with the approval of the Executive Committee.

**DENTAL CARE PROGRAMS COMMITTEE****Subcommittee on Blue Cross and Blue Shield**

FRANKLIN E. MARTIN, *chairman*

EDWARD U. AUSTIN

FREDERICK G. HASTY

T. S. FLEMING

JOSEPH E. CAMPBELL

**Meetings.** No meetings were held.

**Assignments.** To serve as the liason group between the North Carolina Blue Cross and Blue Shield Corporation and the North Carolina Dental Society in matters pertaining to the Corporation's Dental Health Insurance coverage.

**Results of Service.** The Corporation did not call on this subcommittee for any advice during this year.

**Resolutions**

This report is informational in nature and no resolutions are submitted.

**DENTAL CARE PROGRAMS COMMITTEE****Subcommittee on Industrial Commission**

D. W. SEIFERT, *chairman*

WALTER S. LINVILLE, JR.

H. O. LINEBERGER, JR.

DWIGHT B. HORD

JOHN E. MOSES

The Committee discussed the fee schedule with Mr. William Stephenson, Commissioner for the Industrial Commission, with the result that some fees will be revised upward.

The chairman is to meet with Mr. Stephenson and design a dental insert for the added convenience of dentists in reporting their cases.

The Committee requests that the various District Presidents allow Mr. Stephenson some time on their programs in order that he might explain some of the problems that we are encountering with the program.

### Resolutions

This report is informational in nature and no resolutions are submitted.

## DENTAL EDUCATION COMMITTEE

R. B. BARDEN, *chairman*

THOMAS G. COLLINS  
KENNETH M. RAY

RILEY E. SPOON, JR.  
GUY R. WILLIS

The following is a verbatim report as given to the Committee by the representatives of the administrations and faculties of the dental education programs in our state. No attempt has been made by the Committee to offer detailed criticisms. Study of these programs for the purpose of establishing a valid evaluation would necessarily demand more time and study than this Committee was prepared to devote. We therefore submit our report with only a few comments towards these programs, but with a resolution designed to enable future committees to offer more constructive criticism.

**School of Dentistry, University of North Carolina:** A comprehensive report was given to the Committee at the School of Dentistry at Chapel Hill by Dean James W. Bawden, members of his administrative staff, several faculty members, and the coordinators of the various disciplines as provided for by the revised curriculum. Only the present senior class remains on the old curriculum. In 1973, the entire student body will be on the revised curriculum, and after 1973 the revised curriculum will have been tried and tested. The transitional period continues to be laborious and accompanied by multiple problems; however, the overall opinion of the staff and faculty to date is that the revision is proving to be satisfactory and that the resulting curriculum will be a gratifying improvement. Problems are mostly "positive problems." The multi-discipline approach, team teaching, and preceptor training are accepted by the faculty as an improvement both in didactic and clinical areas.

**DDS Undergraduate Program:** The dental school is now admitting 75 students per year with a four year average attrition rate of 4 percent.

The dental student of today at Chapel Hill experiences a considerably different environment and learning experience than most practicing dentists of today experienced. His basic sciences are better correlated and coordinated with clinical experiences through team teaching and through the grouping and training afforded by the discipline called "Oral Biology." He has the opportunity to elect individual research or in-depth study by virtue of time saved by gleaning the portions of basic sciences laboratory courses that are not specifically related to the practice of dentistry. Today's student will begin contact with a patient in his first year. Here he is introduced to the total-care concept of treating his patient through the concept of health as opposed to disease. Instead of viewing his patient as so many "amalgam points," he anticipates providing all the dental needs of this patient for four years with awareness of how this treatment relates to the patient's total health.

To assure complete clinical training in all disciplines of dentistry, the computer system is utilized. The computer provides a method of screening and matching patients with students' needs as well as providing grade statistics for more accurate and meaningful evaluation of student progress. It is evident that in the future an exceptionally gifted student may possibly complete all basic requirements for graduation in less than

four full years. He will not be held back but be allowed to proceed according to his capabilities. This will ultimately generate extra time for instructors to be applied to slower students.

The five basic disciplines comprising a core curriculum, surrounded by lesser disciplines providing lateral and in-depth training are: Biological Sciences, Oral Medicine, Surgery, Restorative Dentistry, and Ecology. Some of the newer concepts in training include hospital dentistry, community dentistry, occlusion, behavioral sciences, oral biology, in-depth laboratory experiences, electives, and experience in the Intra Mural Private Practice Service.

**Dental Auxiliary Programs:** The Dental Hygiene program increased its enrollment in the fall of 1971 to 60 students per class. This continues to be a two year course essentially unchanged in basic didactic and clinical aspects. Clinical facilities and caliber of instructors in didactic and clinical portion of curriculum appears to be very good; however, the Committee feels that training in radiological techniques and experience in clinical dental hygiene may be insufficient. Each student will see approximately 60 adult patients and 15 child patients in clinical training. The hygiene curriculum does not afford training experience as chair-side assistant.

**Dental Assisting:** This course of training is currently admitting 40 students per year. The course begins in the summer and prepares students, basically, to begin work with the student dentists in the fall. In addition to their didactic work and other clinical experiences, each student has an assignment with a dental student with whom they work the entire year, the course ending the following June.

The Dental Auxiliary Utilization program has 20 employed graduate Dental Assistants. Its specific function is to teach dental students how to work with dental auxiliary personnel. An extension of the DAU program is the "TEAM" program (Teaching Expanded Auxiliary Management). Through this medium dental assistants in the DAU program are being taught expanded duties such as impression taking, insertion of restorations, pulp testing, endodontic cultures, polishing restorations, and collection of diagnostic aids. These procedures are not being taught in the dental assistant curriculum. The school accepts the responsibility of studying logistics, cost accounting, and other considerations to determine whether the Expanded Duty Auxiliary (EDA) can be incorporated in teaching programs in the future. Cost accounting analysis and practical application of such a program in the private office is a large part of the unsolved program. Experimental programs must be undertaken to gather this information keeping in mind that teaching must be oriented to be compatible with conditions that will exist ten years hence. It is conceivable that in the future students may have training in office set-up that will contain one chair-side assistant, one EDA assistant with an assistant, and a dental hygienist. Preliminary experimentation using faculty members has shown this to promise interesting results. Projection of this program into the future indicates that it will be necessary to initiate the didactic program at the community college level followed by clinical experience and training at the dental school or other appropriate sites.

**Dental Auxiliary Teacher Education Program:** The "DATE" Program was conceived and developed at Chapel Hill and is now carrying 20 participants. It is the only program for dental auxiliary teacher education in existence. All participants presently have financial support through the Kellogg Foundation and United States Public Health Service grants. The demand for dental auxiliary teachers is great in all auxiliary fields, particularly in the dental hygiene field, and the DATE program promises to be of help in filling this need.

**Research:** The School of Dentistry at the University of North Carolina is one of five dental research institute centers in the United States along

with Alabama, Pennsylvania, Michigan, and the University of Washington at Seattle. The research program continues to increase and consequently add to overall education of the dental student through influence on basic science courses, availability of research projects by students, and solving of various problems. In spite of this, however, it might appear that research programs oriented towards or concerned with private practice of dentistry may be a neglected area. The research program currently has 35 investigators compared to 6 in 1967, with a total of 90 participating personnel in the entire program. The main source of financial support is the National Institute of Health and National Institute of Dental Research.

**Graduate Programs:** Training in six of the eight approved specialties in dentistry are now being offered at Chapel Hill; namely, surgery, orthodontics, endodontics, pedodontics, periodontics, and prosthodontics. There is the apparent possibility that endodontia may have to be temporarily discontinued because of the problem of faculty availability. The total enrollment in all of the graduate programs currently is 48. Most of the programs have a two year curriculum, though in some instances they are of three years duration.

**Future Planning:** The 1971-72 budget at the Dental School is approximately \$6,000,000 compared to \$2,000,000 budget five and one-half years ago. A former UNC accounting officer is now with the Dental School and is proving to be an invaluable help with fiscal problems. The Dental School derives approximately 40 percent of its financial support from the North Carolina General Assembly, about 30 percent from Federal grants, and the remainder from funds generated by tuition and fees, clinical income, overhead receipts on grants, the Intra Mural Private Practice Service, gifts, and special funds.

The Dental School administration feels that the school must engage in experimental programs in order to anticipate the environment of the general practice of dentistry ten years from the present time.

Through the Health Manpower Act the school is presently receiving \$131,000, and it is anticipated to be increased to approximately \$450,000 next year accompanied by an increase of 8 entering students per class to make this possible. All facilities of the new addition to the Dental School are in use to the extent that a clinic which was anticipated to be a continuing education area is in use by current enrollment of students. Starting in April 1972, the old clinic will be completely renovated and renewed.

Continuing education offered by the school to the extent desired continues to be a problem because of the increased time involvement by faculty members during phasing in of revised curriculum; however, there was an estimated 2,000 continuing education participants this year. It is anticipated that an increase in continuing education programs will be possible after complete change over to revised curriculum after 1973. The Committee feels that it is a part of the school's responsibility to offer leadership in continuing education making basic refresher courses readily available both in time and cost to the dentists of the state and the area it serves.

**Wayne Community College:** This school is located at Goldsboro and offers both dental hygiene and dental assisting programs. Both programs appear to be adequately staffed with qualified dental hygienists and certified dental assistants for the number of students enrolled in each program. Dr. Fred Sproul is head of the Dental Department.

The hygiene department has a capacity of 30 per class but are presently enrolling 26 in each class. The students train for 7 quarters (this includes one summer quarter which adds 110 hours in clinical instruction). In addition to clinical training in school, students participate in 40 hours of on-site training in selected dental offices in private practice. Student also receives 40 hours training as chair-side dental assistant.

Dental assisting program has a capacity of 24 and is currently enrolling

17. Curriculum consists of 4 quarters or 12 months from September to August. Program is currently experiencing a 30 per cent attrition rate. The training program gives the assistant 320 hours in clinical program with on-site training in selected dental offices in Goldsboro and on the Seymour Johnson Air Force Base Dental Clinic. Eighty-eight (88) hours of clinical training are given in the school working with a dentist at the chair.

The clinical facilities at Wayne Community College consist of adequate laboratory space, 3 fully equipped dental treatment rooms with new equipment, pan-o-rex x-ray, and a dental hygiene clinic consisting of 12 units.

**Guilford Technical Institute:** GTI is located at Jamestown and the program consists of both hygiene and dental assisting training. Program presently consists of 26 students in the hygiene program and 23 students in the assistant's program. Dr. George F. Mayer is director.

The hygiene curriculum runs for 21 months and students are required to take the National Board Examinations. The National Dental Hygiene Aptitude Tests are used in selection of students. The dental assisting curriculum is a 12 month program. All students are screened and at present have a SAT score of 850 or higher.

Clinical facilities consist of a 20 chair clinic fully equipped, with operative stools on order. Some difficulty in obtaining a sufficient number of adult patients is creating a slight problem. The hygiene curriculum for the third and fifth quarters are being revised to include training in periodontics.

Of major concern is the fact that the GTI program in dental hygiene has not received full accreditation by the ADA Council on Dental Education. Dr. Mayer and the GTI administration are striving to correct the issues the ADA has pointed out. These are in the areas of assistant director, professional and basic science faculty. Some progress has been made in the staff, but they do not yet have an assistant director.

GTI is projecting future continuing education programs in radiology and is hoping to use funds from the Dental Foundation as matching money for installation of a closed circuit TV from the School of Dentistry at Chapel Hill.

**Alamance Technical Institute:** This school is at Burlington offering a program for dental assistant training only. The school accommodates from 15 to 18 students per class, the course running for 12 months with the usual time off for vacation, holidays, etc. Dr. John Stephens is the head instructor assisted by Mrs. Mildred B. Lynch, CDA, in directing the program. There is one other certified dental assistant instructor. The physical plant consists of two well equipped dental offices and lecture room spaces plus ample facilities for students and faculty. There will be a new school built in Alamance soon and the program anticipates moving into new spaces, and the present one will be used for other purposes. The move is due to expansion in the overall teaching programs at Alamance Technical Institute. The students initiate their clinical program by use of mannequins and are later introduced to clinical dentistry working with Dr. Stephens on selected dental patients at the school.

The administration is currently aware of the new directions that are developing in dental assisting curricula and fully intend to assimilate these programs to their curriculum as is feasible.

There does not seem to be a shortage of applicants for the program, and the admission's policy is directed towards being as selective as practicable.

**Central Piedmont Community College:** This school is located in Charlotte and offers a two year program in Dental Hygiene and a one year program for dental assistants. All students are given the student college placement tests but not for the purpose of screening applicants. The school's philosophy is to accept students on a first come first served basis as long as they qualify. They do not utilize any screening proce-

cedure to select applicants. The administration states that their best screening procedure is that nearly all of the students have been encouraged to go into either one of the programs by either dentists, dental hygienists, or dental assistants. The attrition rate in the dental hygiene curriculum is less than 10 percent while the rate in the dental assisting courses may run as high as 25 percent.

All hygienists are required to take the National Board examinations and to date have not experienced difficulty in obtaining employment. The dental assistants are certified by the American Dental Assistants Association Certification Board and likewise have not experienced difficulty in obtaining employment.

The dental hygiene program is enrolling 40 students and the dental assistant program is enrolling two classes of 16, one starting in October and one starting in January. The dental hygiene program has two full time licensed dental hygienists as instructors plus several part-time licensed dental hygienists as part-time instructors. The dental assistant's program also has two full time certified dental assistants as instructors plus part-time instructors used on demand.

Clinical facilities consist of laboratory space with 16 units and a dental clinic consisting of 30 units. There are 3 fully equipped dental treatment rooms utilizing different types of equipment in each. The radiology training clinic consists of 4 stations and appropriate processing equipment.

Dental hygienists perform most of their clinical work in the school's clinic and in addition spend one week at the Veterans Hospital in Salisbury. Dental assistants work in the school clinic with a Public Health dentist plus training in selected dental offices in the Charlotte area and working with the interns at Charlotte Memorial Hospital.

The school has an advisory board consisting of five dentists, two dental hygienists, two dental assistants, and student representatives from the student body.

**Asheville Buncombe Technical Institute:** This school is located in Asheville and is currently in the state of developing a program for dental hygiene and dental assisting. Efforts started in 1966 and the Institute has been working cooperatively with the local dentists and the various dental organizations, Department of Community Colleges, etc. in order to develop a program for dental auxiliary training for the Western part of the state. In 1968 a dental advisory committee was set up composed of seven dentists in Buncombe County. The program is headed by Mr. James R. Winning, Director, Allied Health Division.

A four story health building was completed in 1971 and one of the four floors is devoted entirely to dental training. There is a 12 chair clinic, 3 dental treatment rooms, radiology center, laboratories, classrooms, and other related spaces. It is expected that all of the equipment for the dental programs will be installed prior to September 1972.

A dentist, who will be a full time employee of the Institute, has recently been acquired, and the remainder of the dental staff is now in the process of being screened and selected.

The dental hygiene program will be a two year program and the school will accept 16 students. The dental assisting program is a one year program and will also accept 16 students in this class. The first classes will be selected during the month of April 1972.

Curricula for the two programs have been submitted to the Council on Dental Education for provisional accreditation and indications are that this program will have no difficulty in getting under way in the fall of 1972.

**Coastal Carolina Community College:** The school is located at Jacksonville and is presently offering the dental assisting program only. Plans are being made, however, to offer a dental hygiene program in the fall of 1972.

Dr. T. J. Pape is the director of Dental Programs and is assisted by two full time certified dental assistants. The school will accommodate up to 20 students and has presently enrolled 17 in this year's class. Applicants

for the program seem to be plentiful, allowing the administration to be somewhat selective in obtaining candidates for the program. They are using the SAT scores plus the Otis IQ Test to help with selecting students.

The program is a 12 month program and the students are tested by the American Dental Assistants Certification Board at the completion of their study. Present curriculum is that it is outlined by the Department of Community Colleges, and the clinical program is carried on both on the local premises plus utilization of facilities at Camp LeJeune Marine Base. Clinical facilities consist of a dental laboratory training unit consisting of 16 units and 3 dental treatment rooms completely equipped, and in addition adequate facilities for administrative personnel and lecture room spaces.

Plans for expansion in the fall to accommodate dental hygienists include a 12 unit clinic plus accompanying facilities for locker room space, patient education, and radiological center.

The community college is in the process of building a para-medical building and the dental department anticipates transferring to this new facility some five years hence.

The school is assisted by a local advisory board consisting of 4 practicing dentists and 2 certified dental assistants.

**Durham Technical Institute:** This school is located in Durham and offers a training program for dental laboratory technicians. The school is directed by Mr. William L. Rogers who assumed his role in 1968 and is the fourth such accredited dental technology program in the United States.

The curriculum consists of a two year academic program or an active total of 21 months. It is set up to enroll 40 students in the first year class and 32 students in the second or graduating class. This arrangement has a built in attrition rate of 8 students in the first year class. The current enrollment consists of 34 students in the first year class and 24 in the graduating class. Last year there were 98 applicants from which 40 students from the first year class were accepted. Pre-admission standards are guided by three testing criteria: (1) wax carving, (2) verbal reasoning, and (3) differential aptitude tests.

The teaching staff receives a large part of its manpower from the staff at the University of North Carolina Dental School in the form of guest lecturers. One of the primary problems at the institute is in procurement of an adequate number of instructors. Mr. Rogers indicates that he could use several more full time instructors to assist with the job of working with the students in the laboratories.

There are 60 such dental technology schools in existence and only 31 of these are accredited. The administration is interested in the improvement of dental technology in our state and enlists help mainly in the area of attracting interested and qualified laboratory technicians for teaching in the school.

**Fayetteville Technical Institute:** This school, located in Fayetteville, is offering a program for dental hygienists only. It consists of a two academic-year curriculum and is currently provisionally accredited by the Council on Dental Education. The program started in September 1971 and therefore cannot be accredited until graduating a class. The program is directed by Dr. David Dunham and is assisted by two licensed dental hygienists for clinical training.

The school is operating in new physical facilities including three fully equipped dental treatment rooms, x-ray room, laboratory, and a 13 unit clinic equipped with mobile air driven units. Current enrollment is 22 students with adequate capacity for 24 students. The curriculum is based on the state curriculum outline working in conjunction with the Council on Dental Education and modifications necessary for local environment.

The school has an advisory committee consisting of three dentists from the local dental society.

The school anticipates starting a dental assistants course in the fall of 1973 and is currently interviewing dental hygienists for employment of a third dental hygienist for next year's programs.

**Western Piedmont Community College:** This school is located in Morganton offering a program in dental assisting. The school has a capacity of 16 students and presently has an enrollment of 11. The program is under the direction of Dr. George Johnson, assisted by one full time certified dental assistant, three part-time dental assistants, two part-time dentists, and a part-time dental hygienist. These faculty members alternate portions of their time with the Western Piedmont Mental Health Center in Morganton.

The facilities consist of three dental treatment rooms fully equipped, two x-ray rooms, laboratory spaces, and one office. Clinical experience for the students is obtained both in the community college center as well as working in the dental clinic of the mental health center.

The curriculum is based on the state curriculum outline working in conjunction with the Council on Dental Education and now has the Council's provisional accreditation. They are expecting a site visit by the Council on Dental Education in 1973 at which time they hope to obtain full accreditation.

The school also has an advisory board composed of local practicing dentists.

The school expects to build a 3,000 square foot clinic consisting of six dental treatment rooms, x-ray spaces, laboratories, two office spaces, reception room, and large conference room. This is expected to be completed in the spring of 1973. At that time they expect to hire another full time dentist.

**Conclusion:** It is the consensus of this Committee that it is the responsibility of the dental profession to keep itself fully informed and to exert its influence toward the proper education of dental manpower in our state. To do so this Committee must necessarily spend more time and involve more people than has usually been customary to effect a valid evaluation of the various educational programs.

### Resolutions

**4. Resolved,** that the Dental Education Committee be enlarged in membership to include two members from the immediate area of each school and one at large to serve as chairman. This Committee then should assume the responsibility of obtaining a detailed report from each school, study each program in detail and subsequently submit an annual report to the House of Delegates with an evaluation of the effectiveness of each program.

### DENTAL EDUCATION COMMITTEE

#### Subcommittee On Continuing Education

JOHN W. GIRARD, JR., *chairman*

M. W. ALDRIDGE

HARRY G. SNYDER

JAMES A. HARRELL

MISS AILEEN CROOM

MRS. CAROL MUMPOWER

MRS. BETTY SCOTT

J. HARRY SPILLMAN

J. FRED SPROUL

MRS. CHARLOTTE W. SUTTON

ROY L. LINDAHL, *consultant*

**Meetings.** The Committee held its meeting on February 11, 1972.

#### Background Information.

1. The 1971 House of Delegates adopted the following resolution:  
(Trans. 26-1971-H.)

**Resolved**, that the North Carolina Dental Society implement a plan for awarding points for those individual dentist participating in continuing education, and be it further

**Resolved**, that each dentist voluntarily commit himself to accumulate over a two year period a minimum of twenty points for continued education on the following basis:

District Meeting	3 Points
Local Meeting	1 Point per day
State Meeting	5 Points
Regional and National Meetings	5 Points
Study Club Meeting	1 Point per day
Continued Education Courses	5 Points

and be it further

**Resolved**, that individual dentist meeting these requirements be given recognition within the North Carolina Dental Society and those exceeding these requirements be given special recognition within the North Carolina Dental Society.

2. The Fifth District Dental Society adopted the following resolution:

**Resolved**, that the Dental Practice Act be amended to require continuing education for renewal to practice dentistry in North Carolina.

3. The 19th Annual District Officers Conference adopted the following recommendation (Paragraph number 4):

"The conference recommended that an appropriate committee of the North Carolina Dental Society explore a meaningful Continuing Education program."

4. The Results of Survey by Board of Dental Examiners (Question number 3):

"Should the North Carolina State Board of Dental Examiners require proof of continuing education as a requirement for license renewal? Yes 665. No 588."

With this information in mind, and since the House of Delegates did not provide any administration execution, the Subcommittee on Continuing Education presents two appropriate resolutions at the end of this report.

#### **Resolutions**

5. **Resolved**, that the General Statutes of North Carolina pertaining to dentistry be amended to provide that continuing education be required for renewal of licensure, and be it further

**Resolved**, that the Dental Practice Act Committee be directed to seek changes in the North Carolina Dental Practice Act requiring meaningful minimal continuing education requirements as a prerequisite for license renewal.

### **DENTAL EDUCATION COMMITTEE**

#### **Subcommittee On Dental Hygienists**

JOE B. ROBERSON, *chairman*

J. HARRY SPILLMAN  
JAMES B. HOWELL

J. HENRY LIGON, JR.  
C. T. BARKER

**Meetings.** The committee held no meetings in 1971 and 1972.

**Actions.** The development of the dental hygiene and the dental assisting programs at the new para-medical facility located at the Asheville-Buncombe Technical Institute in Asheville, N. C.

Referral to the N. C. State Board of Dental Examiners the following questions by the NCDHA.

1. Interpretation of the Dental Hygiene section of the Dental Practice Act.
2. Interpretation of the continuing education for license renewal.

**Information.** In February 1972 Dr. Baker M. Hamilton was selected as Chairman of the Dental Hygiene and Dental Assisting Programs at A. B. Technical Institute in Asheville, N. C. Dr. Hamilton has been stationed with the U. S. Navy at Great Lakes, Illinois.

The new para-medical facility has 31,000 square feet of which 9,800 square feet are devoted to the dental programs. The building is a pre-cast concrete slab type construction. There are twelve chairs in an open clinic, three x-ray rooms and three demonstration operatories and one laboratory. The teaching rooms for the related natural sciences are anatomy, physiology, chemistry, and micro-biology.

In April the departments will have their directors. In May and June the high school applicants will be screened for admission. On September 11, 1972 registration begins and on September 13, 1972 classes begin for sixteen student hygienists and student assistants.

### Resolutions

This report is informational in nature and no resolutions are submitted.

### DENTAL HEALTH COMMITTEE

E. A. PEARSON, JR., *chairman*

LEWIS P. BRATTON  
R. H. POOLE, JR.

DAVID H. SIMPSON  
F. M. STONESTREET

The Division of Dental Health has given exceptional focus during the past year, 1971-72, to laying firm foundations for a statewide program of preventive dental activities. Much of this work has been done in conjunction with the North Carolina Dental Society's Task Force for Community Preventive Dental Health Program.

In addition to the preventive emphasis, the Division has carried on its regular functions in the areas of education, research, and dental care.

The following are highlight developments during the year:

**Legislation.** The Division worked with the Dental Society toward passage of legislation in the 1971 General Assembly which would have provided funds to bolster the Division's preventive activity by: Employment of dental hygienists to work in schools and communities; increasing the number of school fluoridation projects; and conducting continuing education courses on prevention for the dental professions. Despite interest and support, the legislative requests were not granted due to what the sponsors called "tight budgeting."

**Fluoridation.** The Division increased the number of school water fluoridation projects to 17, making North Carolina's the most extensive rural school water fluoridation system in the Nation. The Division assisted in the promotion of community fluoridation. The number of fluoridated communities in the State is 103.

**Education Tools, Materials, Special Projects.** The Division developed and displayed a preventive dental exhibit at both the North Carolina Dental Society and the Medical Society of North Carolina conventions at Pinehurst.

Assisted by Task Force members, the Division developed a kit of tools and materials for plaque control to be used by individuals in demonstration plaque control programs.

The Division developed these educational materials on plaque control: A set of 45 slides to be used in instruction; a how-to-do-it manual, "The

Once-A-Day Way:" "Oral Aids," a listing of preventive products and sources,' a prevention poster for schools and dentists' offices. "Oral Express," a newsletter on prevention activities, was continued.

The Division added plaque control instruction to regular dental health education in schools and communities in a series of experimental projects conducted throughout the State by field staff. Brush-ins (mass application of a special fluoride paste) were conducted by field staff in selected schools.

**Demonstration Workshops — Training Manpower.** The Division of Dental Health and the Task Force conducted seminars, workshops, and/or short courses as follows:

—Preventive dental seminar, April 3, 1971, Chapel Hill, for private practitioners known to be interested in prevention. Purpose of the seminar was to train the dentists in the new techniques, consider methods of incorporating prevention into the private practice, and discuss dimensions of a statewide preventive program.

—Preventive dental course, June 1-3, 1971, Greensboro, for all Division field personnel plus dental staffs of urban health departments and dental departments of community colleges.

—Preventive dental course, April 29-30, 1971, for members of the North Carolina Citizens Committee for Dental Health, Raleigh.

—Preventive dental workshop, December 2-3, 1971, Raleigh, for state staffs of the Extension Homemakers' Association and 4-H Clubs.

—Training seminar, December 11, 1971, Chapel Hill, for a group of private practitioners to serve as faculty for a forthcoming series of workshops for dentists and their auxiliaries.

—Division, Task Force and the trained group of practitioners, conducted five preventive workshops for dentists and their auxiliaries at Chapel Hill, January 8, 1972; Jamestown, January 22, 1972; Goldsboro, February 5, 1972; Charlotte, February 19, 1972; and Asheville, March 18, 1972. The workshops were presented with the assistance of the School of Dentistry, University of North Carolina, three community colleges, and the Buncombe County Health Department.

—The Division employed and trained its first two public health dental hygienists to work in Stanly County and Franklin County health departments. They are providing preventive education, screening services, and referrals in schools and communities.

The extensiveness of the State's preventive activities has captured the interest of many out-of-state agencies and individuals. Division staff and Task force members have answered many requests for information on or talks about developments in North Carolina.

### Resolutions

This report is informational in nature and no resolutions are submitted.

### Report of National Children's Dental Health Week Activities State of North Carolina

February 6-12, 1972

The 1972 National Children's Dental Health Week activities in the state of North Carolina were more extensive and more outstanding than any previous Dental Health Week activities. Dental professionals—dentists, dental hygienists, and dental assistants—sparked activities which involved all segments of the community. Plans were executed which created an awareness of dental health problems, an interest in how these

problems may be controlled, and trial adoption of techniques which can prevent or control dental diseases.

### What are the Facts on Statewide Activities?

#### I. Schools

Some 10,000 Dental Health Week posters were distributed to city, county, and private schools by the Dental Health Division alone. The "Each One Teach One to Floss" poster provided back-up to the hundreds of dentists, dental hygienists, and dental assistants who arranged and presented lessons throughout the state. In addition, requests for the A.D.A. "Happiness is a Healthy Mouth" poster numbered in the thousands. Cumberland County, like many others, had a poster in every school.

School activities were varied. Some examples of the types of presentations carried out by the profession are as follows:

1. Classroom presentations: dentists, dental hygienists, and dental assistants did dental inspections and taught classroom lessons to elementary and secondary school children.

- Thousands of these children received dental care kits and were taught how to brush properly. The student-teaching task forces provided by dental hygiene and dental assisting schools, such as Wayne Community College, lent tremendous assistance to the school programs.

2. Brush-ins were held in Wake, Rutherford, Stanly, Carteret, and many other counties.

3. Contests were sponsored to invite children to learn more about dental health. In Wayne County, the dental society sponsored poster and essay contests for fifth and sixth grade children. Among some 200 final entries, the winners received electric toothbrushes. In Lenoir County, the dental society offered cash prizes of \$15, \$10, and \$5 to the lucky winners of dental health poster, paragraph, poem, and short story competitions. Other schools, such as some in Brunswick County sponsored a Smile Contest. Many other school children were delighted by similar approaches.

4. Special school activities included:

- A. The donation of a film to each school in their area by the Durham-Orange, Alexander Hunter Association.

- B. The production of the play "The Tooth, The Whole Tooth and nothing But the Tooth," by a Wilmington class. A dental health puppet show was undertaken in Oakley Elementary School.

- C. The planning, cooking, and eating of a well-balanced breakfast at one Buncombe County elementary school was undertaken by the school children. They ended this activity by a supervised toothbrushing session.

#### II. Publicity and Media

Every known media was employed to carry dental health messages to our fellow North Carolinians. A conservative estimate of the readers, based on clippings collected by the Dental Health Division alone, sets the figure at some 650,000 newspapers carrying full articles on dental health. This means that most households in North Carolina received information in their local papers. Coverage ranged from a series of four sequential information articles for adults, to the "Mini-Page" in the *Charlotte News* and the *Raleigh News and Observer*, which aimed at the younger set.

Local radio and television stations provided extensive coverage through spot announcements, news stories, children's programs, and interview shows. Two National Children's Dental Health Week chairmen in the Charlotte-Mecklenburg area appeared on local TV programs for interviews and noon news coverage. Dr. Charles Greer, experienced in children's dental health teaching from his work with the Dental Health

Division, entertained children on "Romper Room"—a nationally broadcast TV children's program.

It has been estimated that the one and one-half million households in North Carolina had a dental health message carried into their homes.

Many other publicity channels were used. A few representational examples from around the state have been chosen:

1. Mini-posters of National Children's Dental Health Week's "Happiness is a Healthy Mouth" were sent out in some 12,000 library books in Charlotte-Mecklenburg. In Henderson the mini-posters were carried by bank statements; in Randolph, through dental billings.

2. Street banners, such as those in Goldsboro and Mt. Olive, graced many North Carolina streets. Shopping center, motel, and bank markees greeted North Carolinians with dental health messages.

3. Wayne County post offices were sparked into using dental health messages to cancel stamps, and local dairies agreed to carry Dental Health Week messages on their milk cartons.

4. In Cumberland and about eight other counties, billboards, told motorists of the importance of this week's activities.

5. Information boards were set up in several counties which provided dental information for shoppers. One of the most outstanding, in Goldsboro, was a replica of the smile inspection station on the A.D.A. poster. One hygienist, manning the station, handed out information supplied by the Dental Health Division; while the other, who was costumed as a giant papier-mache tooth, gave sugarless goodies and advice to passers-by.

As you can see, dental professionals cooperated tremendously to carry the dental health message throughout the state.

But for all of us, Dental Health Week lasts the whole year through. The Dental Health Division is currently seeking ways to involve communities in preventive home care programs the year round. We saw the great enthusiasm and community spirit which was demonstrated throughout this Dental Health Week—may I hope that this community interest will continue the year long.

## DENTAL HEALTH COMMITTEE

### Subcommittee on Cancer

W. G. QUARLES, *chairman*

E. JEFFERSON BURKES

C. L. SHAFFNER

R. P. BELTON

JEREMIAH N. PARTRICK

ROBERT W. HOLMES

W. JOSEPH PORTER

T. S. FLEMING

AILEEN B. CROOM, C.D.A.

LLOYD B. STANLEY

MAURICE B. RICHARDSON

CHARLES A. REAP, JR.

MICHAEL B. BUCKLAND

WALTER H. FINCH, JR.

GLENN L. HUNT

CHARLOTTE W. SUTTON, R.D.H.

**Meetings.** Committee business was conducted by personal contact and through telephone conversations between committee members.

**Assignments.** To encourage the local dental societies throughout the state to organize oral cancer detection clinics sponsored jointly with the local units of the American Cancer Society.

### Committee Activities.

1. Committee members made announcements from the floor at all but one of the district meetings asking local societies to sponsor oral cancer detection clinics.

2. Designed cover of North Carolina DENTAL JOURNAL, January, 1972,

Vol. 55, Number 1. Asking support for local society's oral cancer detection clinics.

3. Placed notice in North Carolina Dental Society Newsletter, February, 1972, urging local societies to conduct oral cancer detection clinics.

4. Obtained Three Hundred Forty dollars (\$340.00) grant from North Carolina Division of American Cancer Society to produce film showing the simplicity of conducting the oral cancer detection clinic.

5. Film presentation and display will be jointly sponsored by the North Carolina Dental Society and the North Carolina Division of The American Cancer Society at the annual meeting in Pinehurst. A Registry of all film viewers will be kept and a drawing of the name of one dentist who visited will win a portable R.C.A. television set.

### ORAL CANCER DETECTION CLINICS

September 1971-September 1972

Counties	Total Attendance	No. Dentists Participating	No. of Referrals
Gaston (2 locations).....	393	12	15
Beaufort .....	105	4	
Cabarrus .....	127	5	8
High Point .....	228	18	8
Pitt .....	185	4	
Onslow .....	213	10	9
Mecklenburg (4 locations).....	400	16	
Wake (3 locations).....	204	9	
Wayne .....	142	5	21
Chowan .....	48	3	1
Cumberland			
(Fayetteville) .....	161	36	19
(Fort Bragg) .....	46	19	3
(Pope AFB) .....	30	9	
Robeson .....	517	11	
Stanly .....	353	12	21
Bladen .....	100	2	3
Scotland .....	97	4	4
Columbus .....	160	6	10
New Hanover .....	170	8	6
	<hr/> 3,679	<hr/> 193	<hr/> 120

Dental Assistants and Dental Hygienists worked with the dentists in each of the clinics.

#### Recommendations.

1. Organized statewide program sponsoring oral cancer detection clinics including the combined efforts of the North Carolina Dental Society, The North Carolina Dental Assistants Association and the North Carolina Hygienist Association.

2. Establish the cancer subcommittee as a standing committee with its members serving two year (2) alternating terms.

3. Exhibit film and display at all district and state meetings.

4. Give help to local societies in organizing oral cancer detection clinics through the North Carolina Division of the American Cancer Society.

#### Resolutions

6. **Resolved**, that the Cancer Subcommittee of the North Carolina Dental Society be made a standing committee and carry out the recommendations submitted in this report.

**DENTAL LABORATORY RELATIONS COMMITTEE**JOHN B. SOWTER (1975), *chairman*

JAMES L. COX (1976)

HAROLD E. MAXWELL (1973)

JAMES A. HARRELL (1972)

C. Z. CANDLER (1974)

**Meetings.** The Dental Laboratory Relations Committee will meet with the Professional Relations Committee of the North Carolina Dental Laboratory Association on March 26, 1972. The purpose of the meeting will be to discuss the attitudes of the N.C.D.L.A. and dental laboratory technicians toward licensure.

The chairman was asked by President Wade H. Breeland to attend a seminar on dental laboratory and technician licensure to be held at ADA headquarters in Chicago on April 12-13, 1972.

A report on these two meetings will be made in writing or orally to the House of Delegates on April 16-17, 1972.

**Resolutions**

This report is informational in nature and no resolutions are submitted.

**DENTAL PRACTICE ACT COMMITTEE**FAY H. CULBRETH, *chairman*

ROGER E. BARTON

ROBERT H. WATSON

J. HOMER GUION

WILLIAM D. WILSON

KENNETH M. RAY

**Meetings.** The chairman held meetings with the subcommittee on Specialty Licensure on five (5) occasions during the year.

**Assignments.** The 1970 House of Delegates passed a specialty licensure section of the Dental Practice Act for North Carolina and recommended to the chairman of the Dental Practice Act Committee that it be presented to legal counsel, and to the legislative committee, for presentation to the General Assembly of the State of North Carolina to be enacted into law.

There arose some questions concerning specialty licensure after this direction that would have seemed to have hindered the enactment of the rest of the Dental Practice Act. The chairman of the Dental Practice Act Committee with consent of the Executive Committee, removed the specialty licensure portion from the Dental Practice Act. At the 1971 House of Delegates it was recommended that the specialty licensure be put into a workshop so that a good understanding of the questionable areas could be resolved. A workshop was held at the District Officers Conference in December, 1971 and at that time the main issue was the conditions of announcement. It was suggested and approved at the District Officers Conference that the conditions of announcement of limitation of practice be placed under the rules and regulations of the State Board of Dental Examiners.

Amendments to the General Statutes recommended by the workshop and approved by the Executive Committee on March 5 (Appendix 1) are now submitted to the House of Delegates for its consideration. An appropriate resolution follows.

**Resolutions**

**19. Resolved,** that the revision in Article 2 of Chapter 90 of the General Statutes of North Carolina relative to the practice act (specialty licensure) as submitted by the Dental Practice Act Committee be approved, and be it further

**Resolved,** that the legal counsel make necessary proper corrections, subject to the approval of the Executive Committee, and be it further

**Resolved**, that the Legislative Committee be directed to submit the revisions to the 1973 General Assembly for enactment, and be it further,

**Resolved**, that the Legislative Committee be authorized to make such minor changes to the proposed revisions which may be necessary to secure the approval of the legislative bodies, provided that such changes are approved by the Executive Committee.

## DENTAL PRACTICE ACT COMMITTEE

### Appendix 1

#### Proposed Amendments to Dental Practice Act Relating to Specialty Licensure

**Section 1.** Add a new section following G.S. 90-29.4 reading as follows:

**G.S. 90-29.5—Specialty License.** (a) No dentist shall announce or hold himself out to the public as limiting his practice to, or as being especially qualified in those special areas of dental practice for which specialty licensure is hereinafter provided except those dentists who have obtained a specialty license therefor from the North Carolina State Board of Dental Examiners, referred to hereinafter as 'Board.' The Board shall, subject to its rules and regulations not inconsistent herewith issue specialty licenses to those meeting the qualifications therefor hereinafter set forth in the following specialties, and such other specialties as may hereafter be recognized by the Rules and Regulations of the Board:

Oral Surgery  
Orthodontics  
Pedodontics  
Periodontics

Prosthodontics  
Oral Pathology  
Endodontics  
Dental Public Health.

The Board may by its rules and regulations withdraw recognition of any of the foregoing enumerated specialties or those which it has recognized pursuant to this section for the purpose of specialty licensure. Such withdrawal of specialty recognition, however, shall be prospective only and shall not deprive those theretofor licensed in such specialty of such license or of the right to annual renewal thereof pursuant to Section 31 of this Chapter.

The Board shall promulgate and set forth definitively in its rules and regulations the conduct, activities, and communications of a dentist which constitute the announcing or holding himself out to the public as limiting his practice to, or being specially qualified in those special areas of dental practice for which specialty licensure is required, and other conduct, activities, and communications of a dentist shall not be deemed to constitute the same.

To qualify for a specialty license in any of the foregoing, or in the specialties hereafter recognized by Rules and Regulations of the Board, an individual must:

(1) Have currently in effect a license to practice dentistry in North Carolina or have currently in effect a license duly granted by some other state of the United States or by the District of Columbia to practice general dentistry in that jurisdiction and have met the qualifications for licensure in North Carolina pursuant to G.S. 90-30 except for the examination provisions thereof;

(2) Meet the educational and training requirements for such specialty as promulgated by the Rules and Regulations of the Board.

(3) Satisfactorily pass an examination given by the Board in his specialty for which the applicant seeks specialty licensure;

Provided, however, that any dentist duly licensed by the Board for the general practice of dentistry who prior to the effective date of this Act has limited his practice to any of the above listed specialties, shall be entitled to a specialty license from the Board in such specialty without the necessity of complying with the qualifications for specialty licensure set forth above.

(b) The holder of a specialty license shall be subject to the provisions of Section 90-41 of this Article.

(c) A dentist duly licensed in North Carolina both for the general practice of dentistry and in a specialty may at any time surrender his specialty license and resume the general practice of dentistry."

**Section 2.**—Amend G.S. 90-39 as follows:

(a) By inserting a new sub-section (2) thereof reading as follows:  
"Each application for specialty examination \$150.00"

(b) By inserting the words "or specialty" following the word "dentistry" in line 1 of present sub-section (2) thereof.

(c) By renumbering present sub-sections (2), (3), (4), (5), (6) and (7) as (3), (4), (5), (6), (7) and (8).

(d) By adding the following paragraph at the end of said Section:  
"Provided, however, that where a fee is paid for the renewal of a specialty license there shall be no fee charged for the renewal of the general practice license of such practitioner."

**Section 3.** Amend G.S. 90-41 (f) by inserting the words "specialty licensees" and a comma following the word "licensees," in line 1 thereof.

**Section 4.** Amend G.S. 90-41.1 by adding a new sub-section thereto to read as follows:

"(c) The terms 'licensee' and 'license' as used herein include specialty licensee and specialty license."

## DENTAL SERVICE CORPORATION COMMITTEE

GLENN F. BITLER, *chairman*

F. A. BUCHANAN  
JOSEPH E. CAMPBELL  
JOHN H. DIXON  
CLEVELAND W. FLOYD  
C. P. GODWIN  
W. L. HAND, JR.  
JAMES B. HOWELL

RICHARD S. HUNTER  
ROY L. LINDAHL  
W. STEWART PEERY  
F. D. BELL  
PEARCE ROBERTS  
JAMES M. ZEALY  
WILLIAM G. WARE

**Meetings.** The full committee met on February 6, 1972 and April 16, 1972.

**Assignments.** To enlist membership dentists in the state in the Delta Dental Plan of North Carolina and secure a license to write dental insurance.

**Results of Committee Action.** A state-wide solicitation of all dentists in the state has secured about 673 memberships in Delta Dental Plans of North Carolina.

The following were elected to the Board of Directors: Mr. Max Warren, Mr. Frank Roberts, and Dr. F. D. Bell. These men filled the vacancies created by the resignations of Mr. Andrew Cunningham, Mr. James Kimsey and Dr. E. N. Pridgen.

The treasurer was authorized to pay future expenses incurred by the Corporation from corporation funds.

The first annual meeting of the membership of the Corporation will be held in Raleigh, North Carolina on April 16, 1972. Election of the

Board of Directors will take place at that time and the Board will meet directly after the membership meeting.

The Board authorized a letter be sent out to explain section 7 of the participating dentists agreement which contains the provision for pro rata payment.

Mr. James E. Bonk of Delta Dental Plans Association was the principal speaker to about sixty dentists heading up the solicitation drive on February 6, 1972.

#### Resolutions

This report is informational in nature and no resolutions are submitted.

### ETHICS COMMITTEE

JOHN A. S. REYNOLDS (1976), *chairman*

NEWTON SMITH (1972)

W. L. T. MILLER (1973)

SAMUEL H. ISENHOWER (1974)

VICTOR L. ANDREWS (1975)

**Meetings:** The Committee held meetings on September 12, 1971, and January 9, 1972.

**Assignments:** The Committee was requested to update and clarify the *Code of Ethics* of the North Carolina Dental Society.

**Results of Study:** After careful study of the present *Code of Ethics* of the North Carolina Dental Society, the *Principles of Ethics* of the American Dental Association with official advisory opinions as revised January, 1971, it was determined that updating and clarification would be best served by our adopting the *Principles of Ethics* of the American Dental Association.

It was also determined that in order to promote an understanding of the *Principles of Ethics* that a copy be given to all applicants for the Board examination and a copy and instructions be given to all senior dental students at UNC.

#### Resolutions

**7. Resolved,** that the Principles of Ethics of the American Dental Association shall be the *Principles of Ethics* of the North Carolina Dental Society and its component societies as provided in Article XIV of the *Bylaws*, and be it further

**Resolved,** that the *Code of Ethics* of the North Carolina Dental Society, adopted in 1959 and amended in 1960, 1963, 1966, be rescinded.

### FEDERAL DENTAL SERVICES COMMITTEE

T. EDWIN PERRY, *chairman*

WILLIAM S. KETCHAM

JAMES L. COX

FREDERICK G. HASTY

HAROLD W. TWISDALE

**Meetings.** No formal committee meetings have been held.

**Assignments.** The duties of the Committee are:

- a. To act in a liaison capacity to the Veterans Administration.
- b. To formulate programs for the participation of dentists in disaster programs.
- c. To review and study programs of dental care for members of the federal dental services and their dependents.

**Activities.** The Cumberland County Dental Society has instituted an effort to have the so-called "remote" classification by the Department of Defense of the Fort Bragg-Pope Air Force Base removed. At the same

time the Onslow County Dental Society has instituted an effort to prevent action by the Defense Department to designate Camp LeJeune as a so-called "remote" area, thereby requiring the assignment of additional service dentists to care for the civilian dependents. These additional dentists would be procured by the doctors draft facilities. In each case the local dental societies have indicated that sufficient dentists are available within a reasonable distance to the installation for adequate care.

A member of the Federal Dental Services Committee is vitally involved in each of these cases and acts as a direct liaison with the chairman and the executive secretary. The North Carolina Dental Society, through this Committee, has provided the requested support for the efforts in these two geographical areas.

Presently, members of Congress from North Carolina have been asked to lend their support to these two efforts and have replied favorably.

There has been no activity in the Veterans Administration area.

No changes were made in existing disaster preparedness assignments and procedures.

### Resolutions

This report is informational in nature and no resolutions are presented.

## HOSPITAL DENTAL SERVICE COMMITTEE

WILLIAM JOSEPH PORTER, *chairman*

WILLIAM A. WEATHERS

R. DONALD COFFEY

FREEMAN C. SLAUGHTER

JEREMIAH N. PARTRICK

BAXTER SAPP, JR.

**Results of Study.** The Fifth District was evaluated by Dr. Jeremiah Partrick. We were interested in the approval of the hospitals for the A.D.A. The clinic in Wilmington has not been approved by the A.D.A. There is a new hospital being constructed in Jacksonville, N.C. which is being set up for use by the dentists in the area. They have been conferring with the oral surgeons in the area in order to see that proper equipment is present. It is hoped that it will receive A.D.A. approval.

The Third District was evaluated by Dr. Sapp. He felt their hospital situation was in good shape. He did report that Watts Hospital has recently activated a dental service which permits general anesthesia for oral surgery as well as for operative dentistry.

The Second District was under the auspices of Dr. Freeman Slaughter. He felt that dentists working in the hospital should be better prepared to handle the problems connected with hospitals. It is apparent they are not receiving adequate training in dental school. This could be corrected rather easily. He also reported that Cabarrus Memorial Hospital has not been approved by the A.D.A. They are in the midst of an enlargement program and he felt that they should have an accreditation visit as soon as convenient.

The Fourth District had Dr. Donald Coffey, Jr. as its committee member. He reported that the hospitals in the area were all A.D.A. approved in regard to their dental facility.

The First District had Dr. William Weathers reporting. He stated that both Western Carolina Center and Broughton Hospital have been approved by the A.D.A. The general condition of dental clinics in the area is good.

**Summary.** The Hospital Dental Service Committee has made several decisions in regard to questions arising during 1971-72. We advised the A.D.A. Council to make direct payment to the individuals who conduct evaluation surveys throughout the state.

This committee is also now a new representative to the North Carolina

Committee on Patient Care. We were asked to represent the North Carolina Dental Society. The committee chairman is presently the representative to this committee for the North Carolina Dental Society.

In conclusion, we would recommend that all hospitals with dental clinics make every effort to have A.D.A. approval. This would greatly facilitate maintaining the proper standards and procedures to represent dentistry properly in the hospital environment.

#### Resolutions

This report is informational in nature and no resolutions are submitted.

### INSURANCE COMMITTEE

J. S. D. NELSON (1973) *chairman*

DERWOOD L. ASHWORTH (1974)

THOMAS L. BLAIR (1975)

WALTER S. LINVILLE, JR. (1972)

JOHN S. DILDAY (1976)

**Meetings.** The Committee held meetings on May 9, 1971 and September 26, 1971.

**Assignments.** The survey and assessment of the various programs endorsed by the North Carolina Dental Society.

**Results.** 1. At the September meeting N. C. Blue Cross and Blue Shield, Inc. asked for, and received, relief from the guidelines provision requiring 120 days advance notice for a change of premium. Due to adverse loss experiences wherein indemnities exceeded premiums in every quarter since inception of the program, it was found necessary to raise premium rates in the hope for a more favorable balance.

2. At the September meeting it was decided to recommend to the Executive Committee that the North Carolina Dental Society engage an insurance consultant. It was further recommended that Harvey Sarner be engaged for this function and to survey all our insurance programs with the objective of improving the provisions and/or premiums wherever possible within the existing framework. At its December meeting the Executive Committee accepted this recommendation, and Mr. Sarner is presently engaged in the aforementioned survey and study.

#### Resolutions

This report is informational in nature and no resolutions are submitted.

### LEGISLATIVE COMMITTEE

MOTT P. BLAIR, *chairman*

H. ROYSTER CHAMBLEE

L. C. HOLSHOUSER

GEORGE G. DUDNEY

PAUL E. JONES

C. B. TAYLOR

**Meetings.** No formal meetings have been held.

**Assignments.** The 1970 House of Delegates directed the Legislative Committee to submit to the 1971 General Assembly amendments to the Dental Practice Act and the Dental Hygienist Act (TRANS. 15-1970H and 16-1970H).

**Results.** The 1971 General Assembly passed the amendments to the Dental Practice Act and the Dental Hygienist Act.

**Preventive Dentistry Program.** Senate Bills 311 and 312, which provided for a statewide preventive dental program for North Carolina as designed and developed by the Society's Task Force for Community Preventive Dental Health Programs, was not funded by the General

Assembly. The tight budget and lack of funds squeezed this program out of the Appropriations Bill.

**Members of General Assembly.** The North Carolina Dental Society is grateful to Senator Marshall Rauch of Gastonia, Senator Hector McGeachey of Fayetteville, and Representative Ike Andrews of Siler City for their interest and help during the 1971 General Assembly.

**Children's Dental Health Act of 1971.** This act was passed in the U. S. Senate on December 10, 1971, and referred to the House of Representatives. At the request of ADA Washington Office Representative Richardson Preyer was contacted to sponsor a counterpart bill in the House. Congressman Preyer has now sponsored this legislation in the House.

#### Resolutions

This report is informational in nature and no resolutions are submitted.

### LONG RANGE PLANNING COMMITTEE

J. B. FREEDLAND (1976), *chairman*

R. B. BARDEN (1973)

J. A. HARRELL (1974)

A. C. CURRENT (1975)

J. M. JOHNSON (1972)

B. D. BARKER, *Consultant*

**Meetings:** The Committee held no formal meetings during this current year. Various issues were discussed via correspondence and telephone and it was the consensus that no resolutions be presented at this time.

#### Resolutions

This report is informational in nature and no resolutions are submitted.

### LONG RANGE PLANNING COMMITTEE

#### Subcommittee on Central Office

C. W. POINDEXTER, *chairman*

NORMAN F. ROSS

JOSEPH M. JOHNSON

Due to the unsettled nature of the physical location of the central office, this subcommittee feels that no report is appropriate at this time.

#### Resolutions

This report is informational in nature and no resolutions are submitted.

### LONG RANGE PLANNING COMMITTEE

#### Subcommittee on Redistricting

CHARLES W. HORTON, *chairman*

C. E. CRANDELL

WALTER S. LINVILLE, JR.

WALTER H. FINCH, JR.

ROBERT B. LITTON

JAMES E. GRAHAM, JR.

W. KENNETH YOUNG

**Meetings:** The Committee met February 20, 1972 in Greensboro, N. C. Much of the year prior to this was spent in gathering information from sources at the local, state, and national levels.

**Assignments:** One of the repeated suggestions from the respondents polled by the Long Range Planning Committee was the critical need to review and re-evaluate the present component districting of our State Society.

**Recommendation:** That a Committee representing each of the districts be established to review and study the present structure for the purpose of evaluating:

1. The geographic convenience and compatibility of membership.
2. Communication and administrative efficiency with the district and the State Society.
3. Representation.
4. Over-all achievement of the functions generally ascribed to district level activities.

**Committee Action:** The Committee for Redistricting has not completed its study but in answer to the above assignments by the Long Range Planning Committee, the following guidelines have been established.

1. Geographically, the size of the components will be reduced, and attendant with this of course, will be a corresponding increase in the number of component societies. Convenience of transportation and compatibility of various cities and counties is an important consideration. The multi-county planning areas as designated by the State Government will be useful to some degree in establishing boundaries for new components.

2. At present, a wealth of information is sent to the secretaries of component societies from the ADA and the State Society. From this point on, it is dead end. The component society officers have no method by which they can reach the members with this information.

By the same token, the reverse is true. There is no realistic way in which the component officers can gather information in their districts because they are too large. Communication is somewhat in-effective in both directions. Communication and administrative efficiency can be improved with more compact components.

The Committee feels that component societies should have the opportunity to meet at least quarterly.

3. Representation in the House of Delegates for each component society should be governed, within reason, according to the number of dentists in each component. The Committee feels that components should be somewhat more equal in size in terms of numbers of dentists, but that they should not be rigidly limited.

4. In the past, the component societies have performed their duties as well as was possible under the conditions prevailing. Component societies as now constituted are not viable local organizations. The proliferation of local societies un-associated with organized dentistry has usurped most functions generally ascribed to district level activities.

The Committee feels our Society needs component organizations capable of rapid, decisive action to deal with government and third party agencies. Many problems for dentistry are in the making. The only answer is to create the necessary machinery to cope with the multitude of problems — some of which there is yet little awareness on the part of the profession.

**Commentary:** The Committee is well aware of the far reaching effects and the difficulties involved in redistricting the State Society. 1921 was the year the Society last formed new districts. Needless to say, great changes have occurred since that time. Large concentrations of population have developed rapidly in some areas with only moderate growth in other areas. The only thing we can be sure of is change and we must accommodate.

The Committee realizes that we are comfortable with the old structure of the districts and that such that is sentimental and traditional will tend to influence the thinking of the delegates.

The Constitution and By Laws, method of election of State Officers, and many other changes will be in the offing. Old alliances must be broken and new ones formed.

The Committee can only hope the delegates will face the future with an open mind and do what is necessary to improve the organizational structure of dentistry to make even greater progress possible.

**Recommendations:** The chairman requests that the Committee be re-appointed so that we may continue our work.

### Resolutions

This report is informational in nature and no resolutions are submitted.

## LONG RANGE PLANNING COMMITTEE

### Subcommittee on Redistricting

#### Supplemental Report 1

The committee for Redistricting wishes to bring to the attention of the membership the five district geographic boundaries which now compose the North Carolina Dental Society. With only minor changes these districts have existed with these boundaries since 1921.

The number of members of the North Carolina Dental Society located within these component societies is as follows:

First District .....	280
Second District .....	370
Third District .....	353
Fourth District .....	237
Fifth District .....	223

On the attached map please note their present size makes it impossible for the district societies to function for the purposes for which they are assigned to perform.

The committee wishes also to bring to the attention of the membership a second map with proposed districts. There are nine districts labeled, A, B, C, D, E, F, G, H, I. All districts are smaller in terms of geographic size.

The committee wishes to solicit any and all comments from the membership of the Society concerning specific local situations which might be helpful in the formation of new districts. We wish to emphasize that the new district lines are only tentative and are by no means rigidly fixed to date. The committee readily admits that we do not yet possess all the information necessary to draw new district lines which would best serve the interest of all local areas. For this information we must depend upon the membership for guidance.

Please use the map to designate any changes you feel should be made and state the reasons why you feel this would be of benefit to the Society in the particular area in which you are interested.

Listed below are the number of licensed dentists in the designated areas.

A 155	E 266
B 190	F 165
C 204	G 204
D 140	H 190

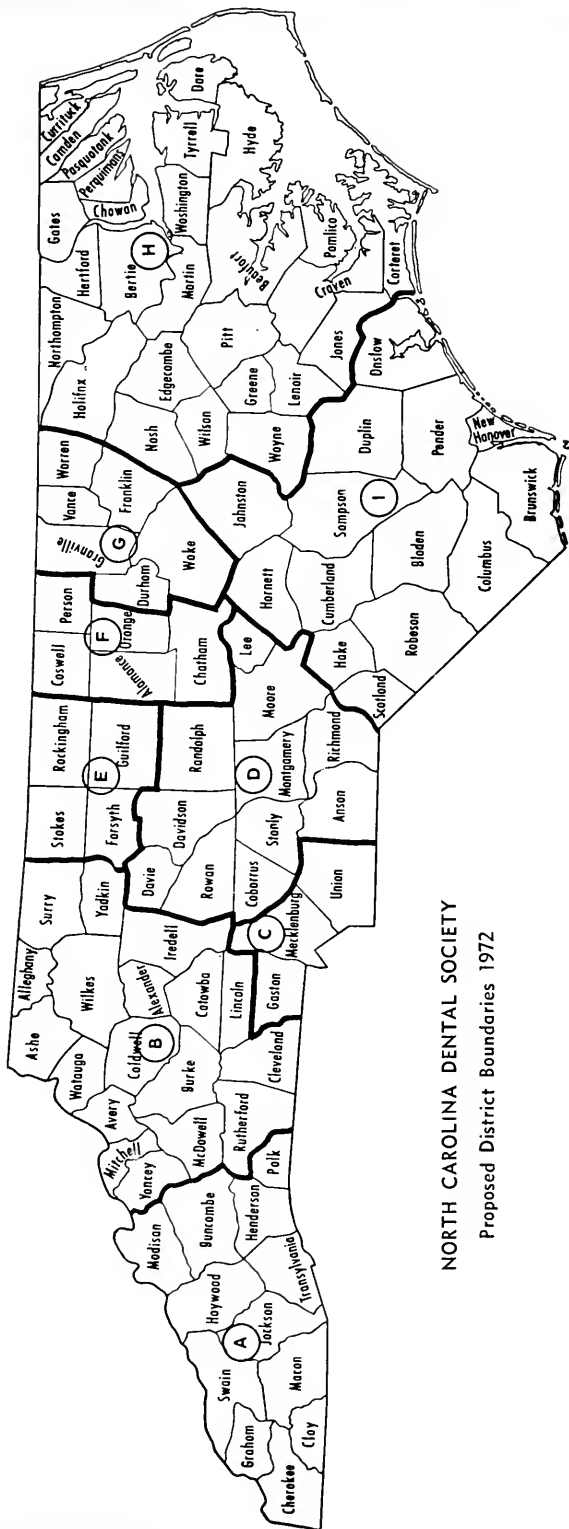
I 177

Help and suggestions from all members of the North Carolina Dental Society is earnestly solicited by the committee.

### Resolutions

This report is informational in nature and no resolutions are submitted.





NORTH CAROLINA DENTAL SOCIETY  
Proposed District Boundaries 1972



(2) All known complaints were handled at local level by individual members. There was no need to call the whole committee together for purposes of handling complaint.

### Resolutions

This report is informational in nature and no resolutions are submitted.

## PUBLIC RELATIONS COMMITTEE

DAVID H. FRESHWATER, *chairman*

WILLIAM A. CURRENT

M. LYNWOOD CHERRY

DONALD D. CULP

RICHARD S. HUNTER

This Committee and the Publicity Committee have been synonymous for the past several years. Most of the activity has consisted of acquiring newspaper coverage for our various meetings.

The public image of the dentist has not suffered, however, because our public relations is best managed by each member doing what he can to gain his patients' good will. Furthermore, programs sponsored by local societies, such as Children's Dental Health Week, Oral Cancer Detection Clinics, and the Dr. Dial series have done much to increase public awareness of the importance of the dentist to total dental health.

Our relationship with the public becomes increasingly important as we are drawn into more socialized programs. Perhaps it would be wise for the Society to take this Committee seriously now. Professional help could be obtained to show how we could improve our public posture. The results and suggestions could then be given to each member for his action.

### Resolutions

This report is informational in nature and no resolutions are submitted.

## REGIONAL BOARD STEERING COMMITTEE

ROGER E. BARTON, *chairman*

R. H. WATSON

C. W. POINDEXTER

**Meetings:** A Steering Committee meeting was held on December 1, 1971. Members of the Committee attended the following meetings relating to the Regional Board for the Southern Region of the United States: Meeting of the Southern Conference of Dental Deans and Examiners in Charleston, S. C. on September 11, 1971, Drs. Barton and Watson; special called meeting of the Southern Conference of Dental Deans and Examiners in Atlantic City on October 9, 1971, Dr. Watson; Meeting of the Southern Conference of Dental Deans and Examiners in San Antonio, Texas, January 8 and 9, 1972, Drs. Barton and Watson.

**Assignments:** The 1971 House of Delegates adopted the following resolution (Resolution 32-1971-H):

**Resolved**, that the President of the North Carolina Dental Society appoint a special committee to serve with the Practice Act Committee to make a complete study of the Regional Examination Concept of evaluating candidates for licenses, in conjunction with the North Carolina State Board of Dental Examiners; and be it further

**Resolved**, that the results of the study be reported to the Executive Committee and the House of Delegates in 1972."

**Results of Study:** The Steering Committee had access to the North East Regional Board of Dental Examiners, Incorporated, Minutes from February 1, 1968 through January 9, 1971. In addition, the Committee

had access to the Format of the 1971 North East Regional Board, the Constitution of the North East Regional Board and the Manual of Instructions for Examiners of the North East Regional Board. This material provided the Committee with an enlightening insight into the mechanism and problems associated with a Regional Board already in existence. The Committee also reviewed the results of a questionnaire prepared by the North Carolina State Board of Dental Examiners relative to Regional Boards, reciprocity, and expanded functions of auxiliary personnel. The Committee was also aware of the fact that the American Dental Association has urged the establishment of Regional Examining Boards and that the National Board of Dental Examiners are presently working on National Clinical Examining Boards with a proposal to be presented in the Spring of 1972 for a National Clinical Testing Service.

The Committee after attending the various meetings cited above and reviewing the available material, is of opinion that two major problems exist that preclude the immediate involvement of the State of North Carolina in a Regional Board Format. The local problem, from the Committee's viewpoint, is the present structure of the Dental Practice Act, which upon strict interpretation would not permit the State Board of Dental Examiners to become involved in a Regional Testing Service. The second major problem appears to be a lack of established criteria of evaluation that would be acceptable to all the State Boards involved in a Regional Testing Service. On the other hand, there are numerous values of a Testing Agency that would accrue to the various State Boards, to the applicants, and to dental educators in the region. These values may out-weigh the disadvantages of a regional board, but the Committee felt that this determination was not within the realm of the charge placed on the Committee by the President of the North Carolina Dental Society.

At the special meeting of the Southern Conference of Dental Deans and Examiners in Atlantic City on October 9, a committee was appointed to study the concept and feasibility of a testing agency in the Southern Region to provide data for licensing bodies in the clinical aspects of their examinations. This Committee provided a comprehensive report to the membership of the Southern Conference of Dental Deans and Examiners on January 9, 1972 at the meeting in San Antonio, Texas. The Steering Committee is in accord with the report presented and wishes to endorse the summary of the report which is as follows: "... it is to be emphasized that a testing agency in this region to examine clinical procedures is not a licensing body — only another resource to help individual boards make their determinations of the applicant's qualifications for licensure."

"It is fully recognized that all states will not participate at this time, but it is stressed that all in this conference assist in structuring such an examination for the benefit of all."

The Committee is also in accord with the three recommendations passed by the membership of the Southern Conference of Dental Deans and Examiners at the San Antonio meeting as follows:

I. "Accept in principle the philosophy and document presented for the establishment of the Southern Regional Evaluation and Testing Agency.

II. Appointment of a special committee to develop the guidelines for the establishment of the agency.

III. The Southern Conference of Dental Deans and Examiners should allocate appropriate funds for the implementation of the special committee functions."

A copy of the *Ad Hoc* Committee of the Southern Conference of Dental Deans and Examiners Report dated December 6, 1971 is attached to the Committee report for reference purposes.

The consensus of the Committee is as follows:

1. The North Carolina Dental Society planning should be geared to the projected activities of ten to fifteen years in the future and not the immediate years ahead.

2. North Carolina Dental Society should lend encouragement to the work of the Southern Conference of Dental Deans and Examiners as it pertains to the study and preparation of a proposal for a regional examining system in the South.

3. The North Carolina Dental Society should emphasize that accompanying or included in the proposal should be a standardization of criteria of evaluation to be utilized in a Southern Testing Agency.

4. The Practice Act Committee in conjunction with the State Board of Dental Examiners should instigate immediately a study of the feasibility of changing the present dental practice act to permit more flexibility in the granting of dental licenses, with the results of this study to be presented at the House of Delegates in 1973.

5. The State Board of Examiners should be encouraged to communicate with Counterpart Boards in neighboring states regarding attitudes and mechanisms concerned with a Southern Regional Testing Agency.

6. The North Carolina Dental Society should take no positive action regarding clinical testing agencies until the facts have been established on the proposed National Testing Service and the Southern Conference of Dental Deans and Examiners Committee report on a Southern Regional Testing Agency to be presented at the annual meeting in 1973 is thoroughly reviewed.

7. A committee, similar to the present Steering Committee, should be constituted to study the proposals made regarding either National or Regional Testing Agencies and report the progress made and recommendations to the North Carolina Dental Society through the 1973 House of Delegates meeting.

### Resolutions

8. **Resolved**, that the President of the North Carolina Dental Society direct the Dental Practice Act Committee in conjunction with the State Board of Dental Examiners to study the feasibility of changes to the Dental Practice Act to permit more flexibility in granting licenses and to propose such changes, if any, at the House of Delegates in 1973.

9. **Resolved**, that the President of the North Carolina Dental Society appoint a committee to continue the study of an evaluation of the National or Regional Testing Service and make recommendations, at the appropriate time, to the House of Delegates concerning the involvement of North Carolina in such a testing service.

### Copy of AD HOC Committee of SCDD&E Report

TO: Membership of SCDD&E

DATE: December 6, 1971

FROM: AD HOC Committee of SCDD&E

SUBJECT: Analysis of the Need for A Regional Testing Agency in the South

At the special workshop meeting of the SCDD&E in Atlantic City on October 9th a committee was appointed to study the concept and feasibility of a testing agency in the southern region to provide data for licensing bodies in the clinical aspects of their examinations. The committee composed of educators and examiners was to meet prior to the Southern Conference meeting January 7, at which time their report would be considered by the membership of the Conference.

On November 14 the committee met in Atlanta and explored the many ramifications—both good and bad—of this very controversial subject. Their report is as follows:

It was unanimously agreed that:

(1) State boards have the sole duty and responsibility of determining a candidate's competency in his petition for licensure in their jurisdiction.

(2) Results of any examination administered by such a testing service are to be utilized by the individual boards in any manner they choose.

It is conceivable that one state may accept—for example—350 as a passing grade, whereas another might require 425 before accepting the results.

(3) It was clearly recognized that this testing service would not be utilized by all boards. In developing this resource for those states who desire such a service, there is to be no action or implication that would in any manner impugn the rights and prerogatives of those who do not choose to make use of the services provided.

(4) Even though a state might not plan to use the facilities of such a testing agency in the foreseeable future, it would have the prerogative of participating at a later date. It was emphasized that all states—whether or not they use the regional services—are seriously urged to consider active participation in the development of such services. Each licensing board has developed techniques in testing and evaluation that, combined with others, would truly enhance the product of such a testing service.

Values of a testing agency:

(1) One prime objective would be assembling the composite knowledge and procedures of all the states, thereby creating an even better examination.

(2) Participation by educators in the structuring of such an agency would provide the resources of the various institutions as well as a free exchange of ideas between examiners and educators on what to expect from the new graduate of today and in the future.

(3) The testing agency is NOT a licensing agency, but merely a resource to boards in providing data as to a candidate's clinical competency. Boards may use the results much as do educators use college board scores, high school grades, aptitude tests, etc., in selection of students. Each school places its own value on the significance of the various items used to determine an applicant's acceptability.

(4) The applicant who takes an examination administered by such a testing agency would NOT be given a certificate or any other inference that he had passed or was eligible for licensure. He would be given the numerical results of his endeavors only. Results of these examinations would be left to the interpretation and decision of the individual state board, which may use all or any part of the scores to any degree it finds appropriate in its evaluation of the candidate.

(5) The content or scope of the examination areas will never become fixed or frozen, but will be changed or expanded as the needs of the boards are identified.

(6) To provide the variety of experiences a board may require of a candidate, it would be encouraged to supplement any part of the examination results, or a board might supplement its own evaluation procedures with all or parts of the testing service.

(7) These examinations might be used by an individual who has been required to demonstrate competencies by the board—in other words, a challenge exam.

(8) Board members are already under duress in terms of manpower to fully cover the multitude of duties they are already responsible to handle. In some states significant time could be saved by the use of such an agency.

(9) Some states would find the testing service concept permitted them to utilize far better physical facilities and far more of them.

(10) The creation of such a testing agency by the members of this conference might allay the possibility of a third party assuming such a role, as is written in several health care bills before Congress now.

(11) Such an agency might also be helpful in setting up standards of measurement in individual states for the expanded duties of auxiliaries.

Values that might accrue to the applicant:

(1) Taking the examination in his home environment.

(2) Taking one examination would reduce travel expense.

(3) Patients would be easier for him to procure in his own school, and, conceivably, with one exam serving as the basis for evaluation in one or more states, fewer patients would be necessary.

(4) The applicant would have more time with individual state board members for interviews or other procedures an individual state may require in addition to what they consider acceptable performance in the practical examination.

Values that might accrue to educators:

(1) Scores would be available to them on both current and former graduates. This would be a resource to evaluate their own programs.

(2) Participation in the testing agency would bring the input of their teaching philosophy and objectives into the total concept of the examination.

(3) The appreciation and recognition of the function and responsibility that both the educator and examiner share should produce an even better qualified applicant. The public's health, welfare and safety would certainly be enhanced thereby.

In summation, it is to be emphasized that a testing agency in this region to examine clinical procedures is not a licensing body—only another resource to help individual boards make their determinations of an applicant's qualifications for licensure.

It is fully recognized that all states will not participate at this time, but it is stressed that all in this conference assist in structuring such an examination for the benefit of all.

#### Recommendations:

I. Accept in principle the philosophy and documents presented for the establishment of the Southern Regional Evaluation and Testing Agency.

II. Appointment of a Special Committee to develop the guidelines for the establishment of the Agency.

##### A. Committee composition

###### 1. Two examiners

Two educators

Two licensed, practicing dentists

###### 2. The committee shall use consultants where they feel necessary.

##### B. Selection of the committee members shall be nominations from the membership at large.

##### C. Charge to the Special Committee:

###### 1. The committee shall prepare the first draft for the Constitution and By-laws of the testing agency.

###### 2. The committee shall search for and locate potential sources of funds for the development of the program.

###### 3. The committee shall survey and analyze current state board procedures used to determine a candidate's clinical competency.

###### 4. The committee shall develop a proposal and submit it to all members of SCDD&E as soon as possible but not later than May 1, 1972.

###### 5. The committee shall collect reports from members of SCDD&E and revise the proposal to be presented to the membership by October 1, 1972.

###### 6. The committee shall call a special meeting during or immediately before the annual A.D.A. meeting in 1972, for the presentation of the revised proposal for the testing agency.

###### 7. The committee will present their final proposal for the testing agency at the 1973 annual meeting of SCDD&E.

III. SCDD&E should allocate appropriate funds for the implementation of the Special Committee functions.

The general membership should designate one member of the committee to serve as the representative to DENTS, representing SCDD&E.

Respectfully submitted by the committee:

Dr. Richard Workman (Secretary, Tennessee Board)  
 Dr. Taylor Hamilton (President, Alabama Board)  
 Dr. Ollie Stukes (President, South Carolina Board)  
 Dr. Jose Medina (Dean, University of Florida Dental School)  
 Dr. Schailer Peterson (Assoc. Dean, University of Texas Dental School), Sec.  
 Dr. John Dalton (Past member—Florida Board), Chairman

### RELIEF COMMITTEE

J. W. HEINZ (1974), *chairman*

S. E. MOSER (1976)

S. L. BOBBITT (1975)

J. T. LASLEY (1973)

HERBERT W. GOODING (1972)

**Current Grants:** During fiscal 1971-72 the North Carolina Dental Society Relief Fund will pay out \$4,000.00 in grants to 3 recipients. The ADA Relief Fund will match this amount, so actually the 3 recipients will receive \$8,000.00.

**ADA Refund:** North Carolina received \$2,218.00 from the ADA Relief Fund which represented 100 percent return of contributions by Society members to the 1970-71 ADA Relief Fund Campaign, the regular refund of three-quarters, plus a bonus of one-quarter. North Carolina exceeded its assigned quota of \$1,830.00 by \$388.00 or 21.2 percent.

To qualify for the one-quarter bonus, a constituent must exceed its quota in the ADA Relief Fund Campaign and pay out in grants more than it received from the ADA Relief Fund Campaign.

### Resolutions

This report is informational in nature and no resolutions are submitted.

### TASK FORCE FOR COMMUNITY PREVENTIVE DENTAL HEALTH PROGRAM

CLAIBOURNE W. POINDEXTER, *chairman*

M. W. ALDRIDGE

FRED H. MILLER

RALPH A. YOUNG

FRED J. SPROUL

WILLIAM R. STANMEYER

**Assignment.** To continue the efforts of this special committee appointed for 1970-1971 to develop, activate and foster a comprehensive state-wide preventive dentistry program, utilizing all known techniques which might be an aid in preventing dental disease. The Task Force has maintained the broadest scope in investigating all avenues which showed promise without regard as to whether these approaches would utilize the professional dental office, the dental educational institutions, facilities and services of public health dentistry or public school and community resources.

Our view has been that such an overall program must be multifaceted and that each facet must be developed in perspective so as to achieve its maximum potential within the total effort.

**Activities.** 1. The Task Force formulated and presented a Community oriented preventive dental program to the state legislature for funding through two special appropriation bills. The program was to be administered by the Dental Division of the State Board of Health, with close cooperation and support of the School of Dentistry of the University of North Carolina. While funding was not possible in this past legislature, our program was received with great interest and support. We made many friends and received assurances of future support by many persons in and associated with the legislature.

Although some of our proposals remain inactive due to lack of new funding, many of the facets have been implemented on a limited scale through reallocation of funds within existing budgets, particularly within the Division of Dental Health.

Requests have come for five presentations of the North Carolina program at national or regional meetings. Apparently the comprehensive and innovative features of our proposed program are unusual and our state can be considered a pioneer leader in prevention.

2. A series of five continuing education workshops were or will be held regionally across our state to teach dentists and their auxiliary personnel how to install a preventive dentistry program in an already busy practice on a financially sound basis. Plaque control was the central feature with the one day sessions divided into theory, in-the-chair demonstrations and practical "how to install it" procedures.

Those registered have come from 62 communities in 42 counties. About 400 will have been trained. Additional workshops will be proposed.

These workshops have been most enthusiastically received. The School of Dentistry of the University of North Carolina, Guilford Technical Institute, Wayne Community College, Central Piedmont Community College, and the Buncombe County Health Center have furnished facilities and their cooperation in this venture.

The assistance of many members of the Division of Dental Health in planning, coordinating, publicizing and helping to staff each of these workshops speaks eloquently of the splendid cooperation and support the division has given our society in the work of the Task Force. Many dedicated private practitioners have met, trained and eventually taught in these workshops to share their experiences with professional colleagues.

The Director of the Dental Division of the State Board of Health, Dr. Alex Pearson and the Dean of the UNC School of Dentistry, Dr. James Bawden have furnished valuable input personally into the Task Force effort and have made available facilities and staff to formulate and promote the programs.

**Recommendations.** As dentistry necessarily moves from a treatment oriented to a preventively oriented profession and recognizes and assumes its proper role both within and without the traditional professional office, the committee structure of its organization, the society, must reflect this change.

### Resolutions

**11. Resolved,** that Article II, Standing Committees, of the *Bylaws* be amended by adding "Preventive Dentistry Committee" in the alphabetical order of standing committees, and be it further

**Resolved,** that Sections 18, 19, and 20 of Article II of the *Bylaws* be renumbered Sections 19, 20, and 21, and be it further

**Resolved,** that Article II of the *Bylaws* be amended by adding a new section 18 to read as follows:

**Section 18, Preventive Dentistry Committee.** The duties of this Committee shall be to become and remain apprised of the latest techniques and concepts in the field of preventive dentistry and to promote the utilization of such techniques and concepts by the practitioners, the schools, the public health services and communities of our State.

**12. Resolved,** that the Preventive Dentistry Committee pursue funding of its state-wide community based programs in the next state legislature.

**13. Resolved,** that the Preventive Dentistry Committee continue to promote continuing education opportunities regionally across the state to assist practicing dentists in establishing meaningful in-office preventive programs based on the latest techniques.

**TENURE OF BOARD MEMBERS**

M. W. ALDRIDGE

GUY R. WILLIS, *chairman*

FRANCIS A. BUCHANAN

**Meetings:** The Committee held meetings on December 1, 1971 and January 31, 1972.

**Assignments:** The 1971 House of Delegates suggested that a special committee be formed to study two aspects of the Board of Dental Examiners, one of which was the number of members on the Board, and the other of which was the terms in office or tenure of the Board members, and to submit its recommendations to the 1972 House of Delegates.

**Results of Study:** The duties and responsibilities of the members of the Board of Examiners was thoroughly studied and discussed, and it was determined that at this particular time, both the number of members and terms, or tenure in office, should remain as at present and as designated by the Dental Statutes.

It was felt that at some undetermined time in the future it may be indicated that one or both of these aspects of the Board be reconsidered and reevaluated for possibility of change.

**Resolutions**

This report is informational in nature and no resolutions are presented.  
**RESOLUTIONS**

# Resolutions

SUBMITTED BY  
THE EXECUTIVE COMMITTEE  
AND  
DELEGATES

## Executive Committee HONORARY MEMBERSHIPS

At its meeting March 12, 1972, the Executive Committee voted to recommend to the House of Delegates, that Dr. Louis A. Saporito of Newark, New Jersey, president-elect of the American Dental Association, and Dr. John M. Faust of Hattiesburg, Mississippi, Fifth District Trustee of the American Dental Association, be elected to honorary membership in the North Carolina Dental Society. Appropriate resolutions are presented herewith.

**16. Resolved**, that Louis A. Saporito, D.D.S., of Newark, New Jersey, president-elect of the American Dental Association, be elected to honorary membership in the North Carolina Dental Society.

**17. Resolved**, that John M. Faust, D.D.S., of Hattiesburg, Mississippi, Fifth District Trustee of the American Dental Association, be elected to honorary membership in the North Carolina Dental Society.

## Executive Committee AMERICAN DENTAL POLITICAL ACTION COMMITTEE

At its meeting March 12, 1972, the Executive Committee voted to submit a resolution to the House of Delegates that the Society endorse the organization of a chapter of the American Dental Political Action Committee. An appropriate resolution is submitted with this report.

**Background Statement:** As federal and state legislation continues to have an increased impact on the scope, quality and delivery of dental care in the United States, the dental profession's obligation of responsible leadership in dental health matters clearly extends to the launching of an active and effective role in governmental affairs as they affect the nation's dental health.

The American Dental Association has accepted its responsibility by supporting a separate, voluntary, unincorporated organization known as the American Dental Political Action Committee (ADPAC) to assist dentists and others to achieve more effective participation in the civic affairs.

State dental associations, too, must accept their share of this civic and professional obligation and thus more effectively bring all dentists into active participation.

**18. Resolved**, that the North Carolina Dental Society does endorse and approve the formation of a North Carolina Dental Political Action Committee and does urge all dentists and their families in the state of North Carolina to join, support and contribute to the aims and objectives of this organization and to coordinate its efforts with those of the American Dental Political Action Committee (ADPAC).

## Wade H. Breeland, President DELEGATES TO ADA

The 1971 House of Delegates amended the *Constitution* (Res. 6-1971-H) to provide that the president-elect automatically be made a Delegate to the ADA. By action of the Society in General Session, May 10, 1971,

the amendments were made effective in 1972. Submitted herewith is a resolution which in effect rescinds the amendments of the 1971 House of Delegates.

**21. Resolved**, that Article V of the *Constitution* be amended by striking out the words "The President-Elect" in the second paragraph of Section 1, so that it shall read:

The Delegates to represent this Society in the House of Delegates of the American Dental Association shall be the President, for a term of one year, and additional delegates for terms of three years each in accordance with Article IX of the BYLAWS to equal the number of delegates allocated this Society by the American Dental Association. (Effective 1967)  
and be it further

**Resolved**, that Article V of the *Constitution* be amended by adding the words "The President-Elect" in the first sentence of Section 2. so that it shall read:

**Section 2.** The President-Elect, Vice President, Secretary-Treasurer, Chairman of the Executive Committee, Editor-Publisher, Immediate Past President, and members of the Executive Committee by seniority, shall be alternate delegates as required to equal the number of delegates. Should additional alternates be necessary, they shall be elected for terms of one year each in accordance with Article IX of the BYLAWS. (Effective 1967)

**Joseph M. Johnson, President-Elect**

#### **EXPENDITURE OF SURPLUS FUNDS**

The lease of the property now occupied by the Central Office expires August 31, 1972. Negotiations are now underway for lease of 1,611 square feet of office space in the new Meredith Woods Professional Building, 2310 Myron Drive, Raleigh. It is located just off the Raleigh beltline at the Lake Boone Trail exit. It is anticipated that the move to the new location will be made in July or August. Obviously, the relocation will cost money, including the services of a moving company, draperies and other necessary furnishings and possibly some new office equipment. Since these will be non-recurring expenses, a resolution is herewith presented authorizing the expenditure of surplus funds for this purpose.

**22. Resolved**, that all costs involved in the relocation of the Central Office be paid from surplus or reserve funds of the Society.

# Report of Delegation To A.D.A.

RALPH D. COFFEY (1974), *Chairman*

ERBIE M. MEDLIN (1973)

EDWARD U. AUSTIN (1974)

WADE H. BREELAND (1972)

PAUL E. JONES (1972)

ROY L. LINDAHL (1972)

PEARCE ROBERTS, JR. (1972)

The North Carolina delegation to the American Dental Association met in caucus Sunday, October 10, 1971, at 7:30 a.m. in the Hospitality Suite of the North Carolina Dental Society, in Haddon Hall, Atlantic City, New Jersey. All delegates were present and officers of the Society, except President Wade H. Breeland. Dr. Robert H. Gainey, vice president, was recognized as representing President Breeland, whose illness prevented him from being present. The first order of business was to instruct Mr. Cunningham, executive director, to send a telegram to President Breeland expressing our sympathy and wishing him a rapid recovery. The delegation continued the study of resolutions and reports to be considered by the House of Delegates. This study was begun at the first caucus in Winston-Salem, September 12, 1971.

Monday morning, October 11, we met in caucus with the Fifth Trustee District Organization. At this meeting, Dr. John M. Faust from Mississippi was elected our Trustee to succeed Dr. Arthur W. Kellner of Florida. At the caucus of our delegation on Sunday and the Fifth District caucus on Monday there was considerable discussion of the Task Force report. With numerous resolutions and routine business along with the election of the trustee very little other business could come before the meetings.

All delegates and designated alternates were present at all sessions of the House of Delegates. Dr. Pearce Roberts, Jr. was appointed teller for the Fifth District. At the first meeting of the House only routine business was presented.

Tuesday, October 12, the Reference Committee hearings were held. These were to be terminated at 3:00 p.m. The Reference Committee on the Task Force Report did not adjourn at the appointed hour, but recessed for one hour at 1:00 p.m. and continued until well after the time set for adjournment. The staff of the ADA worked until 7:00 a.m. Wednesday on the report of eighteen pages, which the Reference Committee prepared. This report was the special order of business for Thursday's final meeting of the House. It could not come Wednesday due to special appearances of distinguished speakers and the nominations for the officers. My personal opinion of this report is that it was indeed all-inclusive, and a great job by the members of the Task Force. However, why spoil their work by pressing the House of Delegates to vote intelligently on all phases with only hours to study the Reference Committee recommendations. I do not profess to say it was all good or all bad. Maybe their study, in time, will prove to be all good. Had the ADA taken a stand on dentistry being included in any national health program, the rush and haste could have been dismissed. Many efforts were made to postpone or delete but all failed. You now have had an opportunity to read the report and evaluate the action of the House.

The second caucus of the North Carolina Dental Society was held Tuesday afternoon. The meeting was necessary in order to coordinate

our meeting with the invitations extended to the respective candidates for the various offices.

Wednesday morning we met in caucus with the Fifth District Organization. I offered an amendment to the rules of procedure in the manual to permit any delegation, with the approval of the officers, and space available, invite members of the respective societies to meet with us. The amendment was adopted.

I also recognized and paid tribute to Dr. Paul E. Jones, a delegate or ADA council member for forty years. Dr. Jones has rendered a great service to our profession and is to be commended for a job well done. He concludes his term with the meeting in Atlantic City and has announced he would not be a candidate again.

Needless to say, we did miss our president, Dr. Breeland. However, he was fortunate in having Dr. Robert H. Gainey to carry on for him. Dr. Gainey attended all meetings and performed the duties of the president in excellent style. The Hospitality Suite was an even greater success this past year.

I shall not report to you on the many actions taken by the House and the election of officers as this has been received long ago by all members. I would be remiss if I did not report to you the confusion which came on Thursday. The time of the meeting of the House was moved up to 8:00 a.m., and at 7:15 p.m. that evening four members of the Fifth District were in their seats. Dr. Roy L. Lindahl and I were with two delegates from Florida. Permission was given by me to all of our delegates, to leave at 5:00 p.m. should they desire. With such confusion and the usual important last day I will recommend to the Executive Committee, that the delegation be allowed two days for travel and five days for the meeting, making a total of seven days. The meeting of the House will start on Sunday this year but that will have to be evaluated later as to the effect.

In conclusion, may I say, we anticipate a quieter ADA election this fall as Carlton Williams will be unopposed for president-elect. We will have a contest with Frank P. Bowyer, Jr. of Tennessee and Frank Nicklaus of New York for speaker. This is the line-up as of now. I know our delegation will support Frank P. Bowyer, Jr. from Tennessee. Dr. Alexander Martone of Virginia will run for first vice president.

Should there be any action or inaction which any member would like to question me or any member of the delegation, please do not hesitate to speak up.

Thank you for your confidence in allowing me to serve as chairman for your delegation to the American Dental Association House of Delegates in 1971.

RALPH D. COFFEY, *chairman*  
North Carolina Delegation

# Actions of House of Delegates 1972

HILTON INN

RALEIGH, N. C.

APRIL 16-17, 1972

## ADOPTED:

**1-1972-H. Resolved**, that the agenda on pages iii and iv (blue sheets) be adopted as the official order of business for this session of the House of Delegates.

**2-1972-H. Resolved**, that the list of referrals submitted by the Speaker-of-the-House of Delegates be approved.

**3-1972-H. Resolved**, that the report of the Committee on Rules and Order be adopted, and be it further,

**Resolved**, that the report of the Committee on Rules and Order constitute the rules for the proper conduct of business at this session of the House of Delegates.

**4-1972-H. Resolved**, that Louis A. Saporito, D.D.S., of Newark, New Jersey, president-elect of the American Dental Association, be elected to honorary membership in the North Carolina Dental Society.

**5-1972-H. Resolved**, that John M. Faust, D.D.S., of Hattiesburg, Mississippi, Fifth District Trustee of the American Dental Association, be elected to honorary membership in the North Carolina Dental Society.

**6-1972-H. Resolved**, that the North Carolina Dental Society does endorse and approve the formation of a North Carolina Dental Political Action Committee and does urge all dentists and their families in the State of North Carolina to join, support and contribute to the aims and objectives of this organization and to coordinate its efforts with those of the American Dental Political Action Committee (ADPAC).

**7-1972-H. Resolved**, that the President appoint an Inter-Agency Committee of Dentistry which will make a study of the necessary funds for its continued existence. Such report to be presented as soon as feasible to the Executive Committee.

**8-1972-H. Resolved**, that the President appoint a Research and Survey Committee which will make a feasibility study of various methods of keeping the membership more informed, and be it further

**Resolved**, that it report to the Executive Committee as soon as practical.

## ADOPTED AS AMENDED:

**9-1972-H. Resolved**, that the revision of Article 2, of Chapter 90 of the General Statutes of North Carolina relative to Dental Practice Act (specialty licensure) as submitted by the Dental Practice Act Committee and as amended by the reference committee be approved, and be it further

**Resolved**, that the legal counsel make necessary proper corrections, subject to approval of the Executive Committee, and be it further

**Resolved**, that the Legislative Committee be directed to submit the revisions to the 1973 General Assembly for enactment, and be it further

**Resolved**, that the Legislative Committee be authorized to make such minor changes to the proposed revisions which may be necessary to secure the approval of the legislative bodies, provided that such changes are approved by the Executive Committee.

**ADOPTED:**

**10-1972-H. Resolved**, that our Insurance Committee request an analysis by the Carrier and advice from the Carrier (Blue Cross and Blue Shield) as to what they think would be desirable and appropriate to stabilize the rates of our group coverage.

**11-1972-H. Resolved**, that all costs involved in the relocation of the Central Office be paid from surplus or reserve funds of the Society.

**12-1972-H. Resolved**, that the *Principles of Ethics* of the American Dental Association shall be the *Principles of Ethics* of the North Carolina Dental Society and its component societies as provided in Article XIV of the *Bylaws*, and be it further

**Resolved**, that the *Code of Ethics* of the North Carolina Dental Society, adopted in 1959 and amended in 1960, 1963, 1966, be rescinded.

**13-1972-H. Resolved**, that a committee be appointed to study the feasibility of modifying the structure of Standing Committees with District representation to more closely represent the differences of dentist population extremes of the districts. Also, that the study committee make its report to the State Executive Committee for action, and be it further

**Resolved**, that this same study committee develop a mechanism whereby the President of the North Carolina Dental Society may replace any appointed committee member who fails to fulfill the requirements and obligations of his office.

**ADOPTED AS AMENDED:**

**14-1972-H. Resolved**, that the North Carolina Dental Society strongly urge the North Carolina General Assembly to reinstate the Title XIX (Medicaid) program insofar as the dental program is concerned to its original status prior to August 1, 1971, subject to the following:

1. Further modifications as recommended by the Dental Care Programs Committee of the North Carolina Dental Society and approved by the Executive Committee of the North Carolina Dental Society.

**ADOPTED:**

**15-1972-H. Resolved**, that the North Carolina Dental Society approve a plan for dental care for the inmates of the schools of the North Carolina Department of Youth Development, which will be a cooperative effort of that Department and the Department of Dental Health of the State Board of Health.

**16-1972-H. Resolved**, that the existence of dental coverage through any prepayment mechanism should not be a factor in a dentist's determination of his fees, and be it further

**Resolved**, that a dentist charging in excess of his usual and customary fees, by reason of a patient's eligibility under a dental care plan shall be considered to be in violation of the Code of Ethics, and be it further

**Resolved**, that the attending dentist's statement, otherwise known as the uniform claim forms, and which has been approved by the H.I.C., and the American Dental Association Council on Dental Care Programs, be approved and recommended for routine use by the North Carolina Dental Society, and be it further

**Resolved**, that it is the duty of a member to abide by the decisions of the Review Committee duly constituted by the North Carolina Dental Society pursuant to policies and guidelines for such Review Committee approved by the House of Delegates or the Executive Committee of this Society and to comply with the reasonable requirements of such committee to perform its functions.

**ADOPTED:**

**17-1972-H. Resolved**, that the Peer Review Committee be directed to compile a manual of guidelines for Peer Review Mechanism with the approval of the Executive Committee.

**18-1972-H. Resolved**, that the House of Delegates of the North Carolina Dental Society express their appreciation and gratitude to the Executive Secretary and the Central Office staff for a job well done.

**REJECTED:**

**19-1972-H. Resolved**, that dentists sent into North Carolina by the National Health Service Corps be licensed in the State of North Carolina, and be it further

**Resolved**, that 50 percent of his patients be indigent, and be it further

**Resolved**, that his auxiliary personnel conform to the laws of our State.

**ADOPTED AS AMENDED:**

**20-1972-H. Resolved**, that an appropriate committee of the North Carolina Dental Society develop a proposal for policy on the Society's position on the implementation of the National Health Service Corps in North Carolina, and be it further

**Resolved**, that this proposal be submitted to the Executive Committee of the Society for action and be forwarded to the House of Delegates for review at the next annual session or special session called for this purpose.

**ADOPTED:**

**21-1972-H. Resolved**, that the designated attorney for the North Carolina Dental Society be directed and empowered to use his best efforts to withdraw from the North Carolina Legislature the entire bill regarding specialty licensure, if any part of the bill pertaining to powers of the Board of Dental Examiners relative to rules and regulations of said Board and Subsection (d) of Section 1 of the bill as it is written is altered or changed either before or after its introduction in the legislature.

**ADOPTED:**

**22-1972-H. Resolved**, that Article II, Standing Committees, of the *Bylaws* be amended by adding "Preventive Dentistry Committee" in the alphabetical order of standing committees, and be it further

**Resolved**, that Sections 18, 19, and 20 of Article II of the *Bylaws* be renumbered Sections 19, 20, and 21, and be it further

**Resolved**, that Article II of the *Bylaws* be amended by adding a new Section 18 to read as follows:

**Section 18. Preventive Dentistry Committee.** The duties of this Committee shall be to become and remain apprised of the latest techniques and concepts in the field of preventive dentistry and to promote the utilization of such techniques and concepts by the practitioners, the schools, the public health services and communities of our State.

**23-1972-H. Resolved**, that it be the policy of the North Carolina Dental Society to consider ineligible for membership dentists who hold provisional licenses under G.S. 90-29.3 and dentists who hold intern permits under G.S. 90-29.4 unless they otherwise meet the qualifications for membership as provided in Article III—Membership, Section 2, of the *Constitution*.

**24-1972-H. Resolved**, that Article V of the *Constitution* be amended by striking out the words "The President-Elect" in the second paragraph of Section 1, so that it shall read:

The Delegates to represent this Society in the House of Delegates of the American Dental Association shall be the President, for a term of one year, and additional delegates for terms of three years each in accordance with Article IX of the *Bylaws* to equal the number

of delegates allocated this Society by the American Dental Association.

and be it further

**Resolved**, that Article V of the *Constitution* be amended by adding the words "The President-Elect" in the first sentence of Section 2 so that it shall read:

**Section 2.** The President-Elect, Vice President, Secretary-Treasurer, Chairman of the Executive Committee, Editor-Publisher, Immediate Past President, and members of the Executive Committee by seniority, shall be alternate delegates as required to equal the number of delegates. Should additional alternates be necessary, they shall be elected for terms of one year each in accordance with Article IX of the *Bylaws*.

#### **REFERRED TO CONSTITUTION AND BYLAWS COMMITTEE:**

**25-1972-H. Resolved**, that the Dental Education Committee be enlarged in membership to include two members from the immediate area of each school and one at large to serve as chairman. This Committee then should assume the responsibility of obtaining a detailed report from each school, study each program in detail and subsequently submit an annual report to the House of Delegates with an evaluation of the effectiveness of each program.

**26-1972-H. Resolved**, that the State Board of Dental Examiners request of each dentist, at the time of the annual license renewal, a report reflecting the achievement in continuing education—using such criteria as set forth by the North Carolina State Board of Dental Examiners. This information gathered by the Board be furnished to the House of Delegates for further study of continuing education principles.

#### **REFERRED TO CONSTITUTION AND BYLAWS COMMITTEE:**

**27-1972-H. Resolved**, that the Cancer Subcommittee of the North Carolina Dental Society be made a standing committee and carry out the recommendations submitted in this report.

#### **ADOPTED:**

**28-1972-H. Resolved**, that it be made a matter of record that the following did not pay 1971 dues by December 31, 1971, and were dropped from the roll in accordance with Article VI, Section 6 of the *Bylaws*:

First District: James H. Barnhill, Hickory

Second District: L. E. Wall, Charlotte

Fourth District: Carl B. Moore, Charleston, S. C.

#### **ADOPTED AS AMENDED:**

**29-1972-H. Resolved**, that the President of the North Carolina Dental Society direct the Dental Practice Act Committee in conjunction with the State Board of Dental Examiners to study the feasibility of changes to the Dental Practice Act to permit more flexibility in granting licenses and to propose such changes, if any, at the House of Delegates in 1973, and be it further

**Resolved**, that the President of the North Carolina Dental Society appoint a committee to continue the study of an evaluation of the National or Regional Testing Service and make recommendations, at the appropriate time, to the House of Delegates concerning the involvement of North Carolina in such a testing service.

#### **ADOPTED:**

**30-1972-H. Resolved**, that the Preventive Dentistry Committee pursue funding of its state-wide community based programs in the next state legislature.

**31-1972-H. Resolved**, that the Preventive Dentistry Committee continue to promote continuing education opportunities regionally across the state to assist practicing dentists in establishing meaningful in-office preventive programs based on the latest techniques.

# General Sessions

SUNDAY, MAY 14, 1972

MONDAY, MAY 15, 1972

WEDNESDAY, MAY 17, 1972

## FIRST GENERAL SESSION

Sunday, May 14, 1972

**Call to Order:** The first general session of the 116th Annual Session of the North Carolina Dental Society was called to order by President Wade H. Breeland at 8:45 p.m., Sunday, May 14, 1972, in the Cardinal Ballroom of The Carolina, Pinehurst. Dr. R. B. Barden gave the invocation and observed a moment of silent prayer in remembrance of the following members who died during the past year:

First District: Carl F. Brown, Hickory, March 12, 1971; Edgar D. Jones, West Jefferson, November 29, 1971; Jay L. Woody, Bryson City, September 25, 1971.

Second District: Frank K. Haynes, Charlotte, August 22, 1971; Edgar H. Reich, Lexington, November 15, 1971; Italy M. Waynick, Winston-Salem, June 21, 1971.

Third District: Claude A. Adams, Jr., Durham, May 7, 1971; Henry C. Carr, Durham, February 5, 1972; Marvin R. Evans, Chapel Hill, May 11, 1972; Charles H. Teague, Greensboro, January 17, 1972; Ralph A. Wilkins, Burlington, July 2, 1971.

Fourth District: Sam R. McKay, Red Springs, May 7, 1971.

Fifth District: Dewey Boseman, Wilson, June 11, 1971; Oscar Hooks, Wilson, May 12, 1971; Thomas W. Smithson, Rocky Mount, April 23, 1972; Ramsey Weathersbee, Jr., Wilmington, September 6, 1971.

**Introduction of Officers and Guests:** President Breeland introduced the Society officers and officers and representatives of allied organizations in attendance.

**Auxiliary Scrap Amalgam Drive:** Mrs. Richard M. Fields, chairman of the 1972 North Carolina Dental Auxiliary Scrap Amalgam Drive, presented a check for \$5,710.56 to Dr. James A. Harrell, president, Dental Foundation of N. C., Inc.

**President's Report:** President Breeland presented his report to the Society.

**Address by ADA President-Elect:** Dr. Louis A. Saporito of Newark, N. J., president-elect, American Dental Association, addressed Society members and guests.

**Report of Fifth District Trustee:** Dr. John M. Faust of Hattiesburg, Miss., Trustee, Fifth District, American Dental Association, presented his report to the Society.

**Honorary Memberships:** President Breeland presented certificates of honorary membership in the Society to: Dr. Louis A. Saporito, Newark, N. J., and Dr. John M. Faust, Hattiesburg, Miss.

President Breeland also bestowed the title of "Tar Heel" on Dr. Saporito and Dr. Faust and presented each of them with a Tar Heel pin.

**Nomination of Officers:** President Breeland called for nominations for Society officers for 1972-73.

Dr. James A. Harrell of Elkin was nominated for the office of president-elect by Dr. Keith L. Bentley of North Wilkesboro.

Dr. Robert B. Litton of Shelby was nominated for the office of vice president by Dr. Pearce Roberts, Jr., of Asheville.

Dr. J. Harry Spillman of Winston-Salem was nominated for the office of secretary-treasurer by Dr. G. Shuford Abernethy of Hickory.

Dr. M. W. Aldridge of Greenville was nominated as a delegate to the American Dental Association for a term of three years by Dr. James A. Privette of Kinston.

Dr. Pearce Roberts, Jr., of Asheville was nominated as a delegate to the American Dental Association for a term of three years.

President Breeland announced that further nominations would be accepted at the second general session, prior to election of officers.

**Announcements:** Dr. William A. Mynatt, chairman of the Program Committee, urged the members to attend the scientific sessions on Monday and Tuesday.

Mr. Andrew M. Cunningham read telegrams extending best wishes for a successful annual meeting from: Dr. Carl A. Laughlin, president, American Dental Association; Dr. James W. Bawden, dean, University of North Carolina School of Dentistry; and Miss Aileen Croom, president, North Carolina Dental Assistants Association.

The executive secretary announced that at 5:30 p.m. registration totalled 744, including 342 members.

**Adjournment:** The meeting was adjourned at 10:30 p.m.

## SECOND GENERAL SESSION

Monday, May 15, 1972

**Call to Order:** The second general session of the 116th Annual Session of the North Carolina Dental Society was called to order by President Wade H. Breeland at 8:40 p.m., Monday, May 15, 1972, in the Cardinal Ballroom of The Carolina, Pinehurst. Dr. Robert H. Watson led in prayer.

**Dental Foundation Report:** Dr. James A. Harrell, president, Dental Foundation of N. C., reported on the Foundation's progress during the past year.

**Report of Board of Dental Examiners:** Dr. Robert H. Watson of Charlotte, president, North Carolina State Board of Dental Examiners, reported on Board affairs during the past year.

**UNC School of Dentistry Report:** Dr. James W. Bawden, dean, University of North Carolina School of Dentistry, reviewed the current activities now in progress at the School, including the program of experimentation in the utilization of expanded function auxiliaries.

**Post-Payment Plans:** Mr. John P. Carr, vice president, First Citizens Bank and Trust Co., Raleigh, described professional billing services offered to dentists by his bank.

**Tribute to Dr. Paul E. Jones:** Dr. Darden J. Eure paid tribute to Dr. Paul E. Jones of Farmville for his dedicated service through the years to his profession, his state and his community and presented to him *in absentia* a handsome, engraved silver tray as an expression of the gratitude and appreciation of the members of the Society to Dr. Jones. Because of illness Dr. Jones was unable to be present to receive the award.

**Golf Awards:** Dr. J. O. Thorpe of Charlotte announced the winners in the annual golf tournament.

**Election of Officers:** President Breeland announced the appointment of the following tellers: D. F. Hord, Walter S. Linville, Jr., and R. B. Barden.

President Breeland called for further nominations for the offices of president, president-elect, vice president, secretary-treasurer, and delegates to the American Dental Association.

Dr. Roy L. Lindahl of Chapel Hill was nominated as a delegate to the American Dental Association for a term of three years by Dr. Norman F. Ross of Durham.

There being no further nominations, the following were declared elected by acclamation:

President-Elect—James A. Harrell

Vice President—Robert B. Litton

Secretary-Treasurer—J. Harry Spillman

ADA Delegates—M. W. Aldridge, Pearce Roberts, Jr., and Roy L. Lindahl

**1974 Annual Sessions:** A letter from the Charlotte Chamber of Commerce inviting the Society to hold its 1974 Annual Session in Charlotte was read by the executive secretary. He also read a letter from The Carolina in Pinehurst inviting the Society to return to Pinehurst for its 1974 Annual Session.

Dr. James Harrell moved that the Society hold its 1974 Annual Session in Pinehurst. Dr. S. E. Moser seconded the motion and it was carried.

**Announcements:** The executive secretary read a telegram from Dr. Frank P. Bowyer of Knoxville, Tennessee expressing his appreciation to the Society for its endorsement of him as a candidate for Speaker of the ADA House of Delegates and extending his best wishes to the Society for a successful annual meeting.

Dr. Joseph M. Johnson announced that the Directors of the Dental Foundation would meet immediately following the adjournment of this session and that the Executive Committee would meet at 9:00 a.m. Tuesday morning. He issued an invitation to the presidents of the Third and Fifth Districts to send representatives to the Executive Committee meeting since those Districts were not represented on the Executive Committee. He also announced that meetings of the Executive Committee were open to all Society members who desired to attend.

**Registration:** The executive secretary announced that registration at 5:30 p.m. totalled 1,559, including 704 members.

**Adjournment:** The meeting was adjourned at 10:38 p.m.

### THIRD GENERAL SESSION

Wednesday, May 17, 1972

**Call to Order:** The third general session of the 116th Annual Session of the North Carolina Dental Society was called to order by President Wade H. Breeland at 11:30 a.m., Wednesday, May 17, 1972, in the Cardinal Ballroom of The Carolina, Pinehurst. Dr. Richard P. Belton led in prayer.

**Registration:** The executive secretary announced that registration for the 116th Annual Session totalled 2,449 as follows:

Members:

First District .....	109
Second District .....	208
Third District .....	213
Fourth District .....	160
Fifth District .....	128

Total Members .....	818
Visiting Dentists .....	118

Dental Auxiliary .....	397
Exhibitors .....	168
Dental Assistants .....	488
Dental Hygienists .....	229
Laboratory Technicians .....	58
UNC Dental Students.....	25
Community College Students.....	7
Guests .....	141
<b>TOTAL .....</b>	<b><u>2,449</u></b>

**Installation of Officers:** President Breeland installed Joseph M. Johnson as president for 1972-73 and a delegate to the American Dental Association for a one-year term.

Dr. Johnson then installed the newly-elected officers and ADA delegates as follows: James A. Harrell, president-elect; Robert B. Litton, vice president; J. Harry Spillman, secretary-treasurer; M. W. Aldridge, Roy L. Lindahl, and Pearce Roberts, Jr., delegates to the American Dental Association for three-year terms.

**Presidential Appointments:** President Johnson announced the following appointments: Frederick G. Hasty, member of the Executive Committee for a term of three years and chairman for 1972-73; Darden J. Eure, Jr., general chairman, 1973 Annual Session; Ralph D. Coffey, speaker of the House of Delegates.

**Adjournment:** The 116th Annual Session of the North Carolina Dental Society was adjourned, *sine die* at 12:00 noon.

# Directory 1972-1973

## NORTH CAROLINA DENTAL SOCIETY OFFICERS AND COMMITTEES

### STATE PRESIDENTS

N. C. DENTAL ASSISTANTS  
ASSOCIATION OFFICERS

N. C. DENTAL HYGIENISTS  
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N. C. DENTAL AUXILIARY OFFICERS

N. C. DENTAL LABORATORY  
ASSOCIATION OFFICERS

N. C. STATE BOARD OF  
DENTAL EXAMINERS

## NORTH CAROLINA DENTAL SOCIETY

1972-1973

### OFFICERS

<b>President:</b> Joseph J. Johnson, 426 King Street.....	Laurinburg 28352
<b>President-Elect:</b> James A. Harrell, P. O. Box 858.....	Elkin 28621
<b>Vice President:</b> Robert B. Litton, Box 1346.....	Shelby 28150
<b>Secretary-Treasurer:</b> J. Harry Spillman, 140 Lockland Avenue.....	Winston-Salem 27103
<b>Editor-Publisher:</b> Robert J. Shankle, UNC School of Dentistry.....	Chapel Hill 27514
<b>Speaker of the House:</b> Ralph D. Coffey, P. O. Box 693.....	Morganton 28655
<b>Executive Secretary:</b> Andrew M. Cunningham, 2310 Myron Drive.....	Raleigh 27607

### EXECUTIVE COMMITTEE

<b>Chairman:</b> Frederick G. Hasty (1975), 3401 Melrose Road.....	Fayetteville 28304
Fay H. Culbreth (1973), Suite 200, 4304 Park Road.....	Charlotte 28209
William A. Current (1974), 224 New Hope Rd.....	Gastonia 28052
Wade H. Breeland (1973), Breeland Building.....	Belmont 28012

### DELEGATES TO THE AMERICAN DENTAL ASSOCIATION

RALPH D. COFFEY (1974), <i>Chairman</i>	
EDWARD U. AUSTIN (1974)	JOSEPH M. JOHNSON (1973)
M. W. ALDRIDGE (1975)	ROY L. LINDAHL (1975)
ERBIE M. MEDLIN (1973)	
PEARCE ROBERTS, JR. (1975)	

### ALTERNATE DELEGATES TO THE AMERICAN DENTAL ASSOCIATION

ROBERT J. SHANKLE	JAMES A. HARRELL
WADE H. BREELAND	FREDERICK G. HASTY
F. H. CULBRETH	ROBERT B. LITTON
J. HARRY SPILLMAN	

## STANDING COMMITTEES

**ANNUAL SESSION:** Darden J. Eure, Jr., chairman; Jon W. Couch, Richard P. Belton, Donald D. Culp, Keith L. Bentley.

## Subcommittees

**Arrangements:** Jon W. Couch, chairman; G. A. Haltiwanger, Stuart B. Fountain, William R. Henshaw, Robert M. Fox, Keith L. Bentley.

**Projected Clinics:** James A. Privette, chairman; Frank H. Daniel, R. W. Moye, David Marshburn, Duncan Getsinger.

**Commercial Exhibits:** Charles M. Kistler, chairman; Philip W. Thomas, Larry A. Williams.

**Entertainment:** Mitchell W. Wallace (Entertainment and Dance); Robert H. Watson (Banquet).

**Monitor:** Richard P. Belton, chairman; John L. Cloninger, Robert M. Polk, Jr., Robert H. Owen, Jr., Joe T. Earp, Kenneth Taylor, Jr., Lynn S. Mann, William G. Quarles, Percy W. Jessup, Frank R. Pfau, Norbert J. Schneider, Thomas R. Styers, Kenneth E. Mitchum, Jimmie P. Baucom, Clayton B. Smith, Jr., John R. Dunn, R. Willard Hinnant, Daniel U. Cregar, Jr., John T. Madison, Harry W. Killian, Robert Peck.

**Auxiliary:** T. Hicks Hamrick, Jr., chairman; Julian R. Rogers.

**Program:** Donald D. Culp, chairman; Martin D. Barringer, Michael B. Buckland, R. A. Carnevale, Gerald M. Cathey, Edward F. Harris, Robert H. Sager.

**Publicity:** L. P. Megginson, Jr., chairman; Joe B. Roberson, Mark N. Perlin, Wesley E. Kelly, Garland R. Homes.

**Sports:** John H. Dixon, chairman; E. P. Williams, Robert H. Poole, William C. Bean.

**CONSTITUTION AND BYLAWS:** William G. Schneider, chairman (77); C. P. Godwin (76); Thomas G. Nisbet (75); Charles A. Reap (74); Shuford Abernethy (73).

**DENTAL CARE PROGRAMS:** Charles W. Horton, chairman; James H. Lee, James A. Harrell, D. W. Seifert, Jr., Walter S. Linville, Jr., William G. Ware, Jr., John W. Girard, Jr., George G. Dudley.

## Subcommittees

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**State Peer Review:** James H. Lee, chairman; C. D. Kistler, Lewis W. Lee, William H. Price, Kenneth M. Ray, Maurice B. Richardson.

**Blue Shield:** James A. Harrell, chairman; Harry N. Baldwin, Joseph E. Campbell, Frank H. Walker, W. Stewart Peery.

**Industrial Commission:** D. W. Seifert, chairman; Robert M. Polk, Clarence L. Shoffner, Cleveland W. Floyd, William F. Riddle, Mark N. Perlin.

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## Subcommittees

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**Dental Assistants:** William H. Oliver, advisor; Charles E. Jones, Roy L. Earp, Roger E. Barton, T. S. Fleming, Wilma Wilson, President, N.C.D.A.A.

**Dental Hygienists:** James M. Zealy, chairman; Norman B. Grantham, Joseph R. Suggs, Keith L. Bentley, Carey T. Wells, Jr., C. R. VanderVoort, Linda Heekin, President, N.C.D.H.A.

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**ETHICS:** Robert H. Gainey, chairman (77); John A. S. Reynolds (76); James A. Privette (75); S. H. Isenhower (74); W. L. T. Miller (73).

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**INSURANCE:** J. S. D. Nelson, chairman (73); Derwood L. Ashworth (74); Thomas L. Blair (75); John S. Dilday (76); Donald E. Bland (77).

**LEGISLATIVE:** Mott P. Blair, chairman; Thomas B. Reid, Jr., Charles T. Barker, George G. Dudley (Other appointments pending).

**LONG RANGE PLANNING:** J. B. Freedland, chairman (76); R. B. Barden (73); James A. Harrell (74); A. C. Current, Jr. (75); J. Harry Spillman (77); Gerald M. Cathey, consultant.

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**Redistricting:** Charles W. Horton, chairman; C. E. Crandell, Jr., James E. Graham, Jr., Robert B. Litton, W. Kenneth Young, Walter H. Finch, Jr.

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**RELIEF:** William L. Hand, Jr., chairman (77); S. E. Moser (76); S. L. Bobbitt (75); J. William Heinz (74); J. T. Lasley (73).

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**CHILDREN'S DENTAL HEALTH WEEK:** Keith L. Bentley, State Chairman.

**DENTAL PRACTICE ACT:** Fay H. Culbreth, chairman; Roger E. Barton, C. W. Horton, W. L. Hand, Jr.

**INTERAGENCY COMMITTEE FOR DENTISTRY:** NCDS Executive Committee; District Presidents; Chairman, Long Range Planning Committee; Director, Dental Health Division, N. C. State Board of Health; 6 representatives, UNC School of Dentistry; President, Spurgeon Dental Society.

**REGIONAL BOARD:** Roger E. Barton, chairman; Robert H. Watson, Claibourne W. Poindexter.

# PRESIDENTS OF THE NORTH CAROLINA DENTAL SOCIETY SINCE ITS ORGANIZATION

1856.....	*W. F. Bason	1920-21.....	*J. H. Judd
1857.....	*E. H. Andrews	1921-22.....	*W. M. Robey
1858.....	*B. F. Arrington	1922-23.....	*S. R. Horton
1866.....	*B. F. Arrington	1923-24.....	*R. M. Morrow
1875-76.....	*B. F. Arrington	1924-25.....	*J. A. McClung
1876-77.....	*V. E. Turner	1925-26.....	*H. O. Lineberger
1877-78.....	*J. W. Hunter	1926-27.....	B. F. Hall
1878-79.....	*E. L. Hunter	1927-28.....	*E. B. Howle
1879-80.....	*D. E. Everitt	1928-29.....	*I. R. Self
1880-81.....	*Isaiah Simpson	1929-30.....	*J. H. Wheeler
1881-82.....	*M. A. Bland	1930-31.....	Paul E. Jones
1882-83.....	*J. R. Griffith	1931-32.....	*Dennis Keel
1883-84.....	*W. H. Hoffman	1932-33.....	*Wilbert Jackson
1884-85.....	*J. H. Durham	1933-34.....	*Ernest A. Branch
1885-86.....	*J. E. Matthews	1934-35.....	*L. M. Edwards
1886-87.....	*B. H. Douglas	1935-36.....	*Z. L. Edwards
1887-88.....	*T. M. Hunter	1936-37.....	*D. L. Pridgen
1888-89.....	*V. E. Turner	1937-38.....	*J. F. Reece
1889-90.....	*S. P. Hilliard	1938-39.....	G. Fred Hale
1890-91.....	*H. C. Herring	1939-40.....	F. O. Alford
1891-92.....	*C. L. Alexander	1940-41.....	*C. M. Parks
1892-93.....	*F. S. Harris	1941-42.....	C. C. Poindexter
1893-94.....	*C. A. Rominger	1942-43.....	*Paul Fitzgerald
1894-95.....	*H. D. Harper	1943-44.....	*Clyde E. Minges
1895-96.....	*R. H. Jones	1944-45.....	O. C. Barker
1896-97.....	*J. E. Wyche	1946-47.....	E. M. Medlin
1897-98.....	*H. V. Horton	1947-48.....	*R. M. Olive
1898-99.....	*C. W. Banner	1948-49.....	C. W. Sanders
1899-1900.....	*A. C. Liverman	1949-50.....	Walter T. McFall
1900-01.....	*E. J. Tucker	1950-51.....	A. S. Bumgardner
1901-02.....	*J. S. Spurgeon	1951-52.....	*R. Fred Hunt
1902-03.....	*J. H. Benton	1952-53.....	*A. C. Current
1903-04.....	*J. M. Fleming	1953-54.....	Neal Sheffield
1904-05.....	*W. B. Ramsey	1954-55.....	*B. N. Walker
1905-06.....	*J. S. Betts	1955-56.....	*J. W. Branham
1906-07.....	*J. R. Osborne	1956-57.....	H. K. Thompson
1907-08.....	*D. L. James	1957-58.....	R. D. Coffey
1908-09.....	*F. L. Hunt	1958-59.....	S. E. Moser
1909-10.....	*J. C. Watkins	1959-60.....	*W. B. Sherrod
1910-11.....	*A. H. Fleming	1960-61.....	L. H. Butler
1911-12.....	*P. E. Horton	1961-62.....	N. F. Ross
1912-13.....	*R. G. Sherrill	1962-63.....	E. D. Baker
1913-14.....	*C. F. Smithson	1963-64.....	S. Byron Towler
1914-15.....	*J. A. Sinclair	1964-65.....	Darden J. Eure
1915-16.....	*I. H. Davis	1965-66.....	Pearce Roberts, Jr.
1916-17.....	*R. O. Apple	1966-67.....	J. H. Guion
1917-18.....	*R. M. Squires	1967-68.....	George F. Kirkland, Jr.
1918-19.....	*J. N. Johnson	1968-69.....	Colin P. Osborne, Jr.
1919-20.....	W. T. Martin	1969-70.....	C. W. Poindexter
		1970-71.....	W. L. Hand, Jr.
		1971-72.....	Wade H. Breeland
		1972-73.....	Joseph M. Johnson

\* Deceased.

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ALLIED ORGANIZATIONS**

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<b>Ass't. Secretary:</b> Lurlene Medford, 864 Haywood Rd.....	Asheville	28806
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<b>Past President:</b> Aileen Croom, 411 Robert E. Lee Dr.....	Wilmington	28401

**NORTH CAROLINA DENTAL AUXILIARY**

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<b>President-Elect:</b> Mrs. Leonard Cashion, 1309 Westminster Drive.....	High Point	27262
<b>Vice President:</b> Mrs. N. C. Johnson, Jr., 1505 Country Club Drive.....	High Point	27262
<b>Corresponding Secretary:</b> Mrs. C. Edgar Jones, 17 Robin Hood Road.....	Asheville	28804
<b>Recording Secretary:</b> Mrs. Donald D. Culp, 2510 Lynbridge Dr.....	Charlotte	28211
<b>Treasurer:</b> Mrs. Wallace B. Butler, P. O. Box 338.....	Welcome	27374
<b>Historian:</b> Mrs. G. Curtis Wilson, 1109 Salem St.....	Wilson	27893
<b>Parliamentarian:</b> Mrs. Julian Rogers, 2004 Madison Avenue.....	Greensboro	27403

**NORTH CAROLINA DENTAL HYGIENISTS ASSOCIATION**

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<b>President-Elect:</b> Miss Judy Milspaugh, 5409 Portree Pl., Apt. 12.....	Raleigh	27606
<b>Vice President:</b> Mrs. Donnie Brothers, 2502 Denise Dr.....	Greensboro	27407
<b>Secretary:</b> Mrs. Brenda Reaves, Box 285.....	Mount Olive	28365
<b>Treasurer:</b> Mrs. Libby Royal, Rt. 8, Box 305.....	Raleigh	27609

**NORTH CAROLINA DENTAL LABORATORY ASSOCIATION**

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<b>President-Elect:</b> Willard Perry, Box 86.....	Graham	27253
<b>Vice President:</b> Robert Lanier, 2300 Wayne Memorial Drive.....	Goldsboro	27530
<b>Secretary-Treasurer:</b> James F. Horton, Jr., Box 900.....	Box	27893

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<b>Secretary:</b> Freeman C. Slaughter (1975), 201 Professional Building.....	Kannapolis	28081
Thomas G. Collins (1974), 800 St. Mary's St.....	Raleigh	27605
Cecil A. Pless, Jr. (1973), Suite 120 Doctors Dr.....	Asheville	28801
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\$300.00	\$148.50	\$169.50	\$244.50	\$340.50	\$421.50
250.00	124.50	142.00	204.50	284.50	352.00
200.00	100.50	114.50	164.50	228.50	282.50
150.00	76.50	87.00	124.50	172.50	213.00

<div>Plan L-65</div>		Maximum Accident Benefits Lifetime	Maximum Sickness Benefits To Age 65			
Weekly Benefits		SEMI-ANNUAL RATES				
	Under 30	30-39	40-49	50-59	60-69	
\$300.00	\$184.50	\$211.50	\$289.50	\$388.50	\$421.50	
\$250.00	154.50	177.00	242.00	324.50	352.00	
\$200.00	124.50	142.50	194.50	260.50	282.50	
\$150.00	94.50	108.00	147.00	196.50	213.00	

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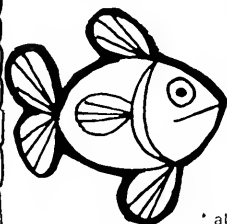
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\$369	C	Main & Upper	Inside & Outside	Upper & Lower
\$409	D	Main, Upper & Empress	Outside Inside & Outside Inside	Upper & Lower Upper & Lower Upper & Upper
\$449	E	Upper Empress	Outside Outside	Lower Lower

\* all prices are based on per person double occupancy plus 10% tax and services.

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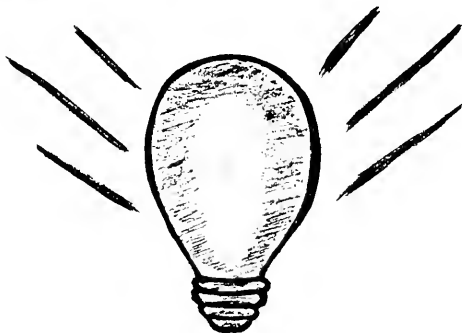
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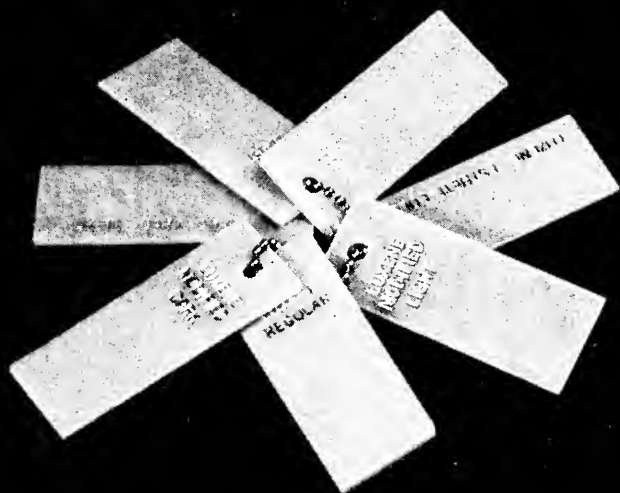
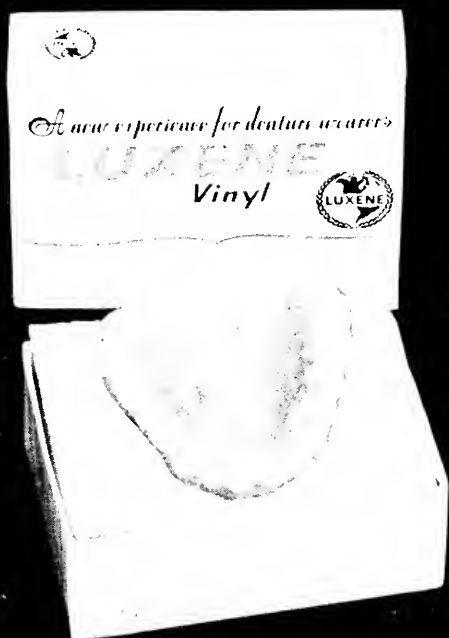
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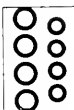


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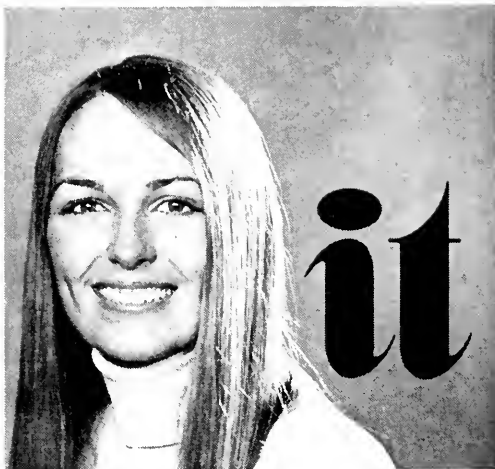
Softex combines over 2,200 bristles with a smaller brush head to provide improved cleaning power.

<sup>\*</sup>Goldman, H. M., and Cohen, D. W.: Periodontal Therapy, ed. 4, St. Louis, The C. V. Mosby Company, 1968, pp. 319-320.



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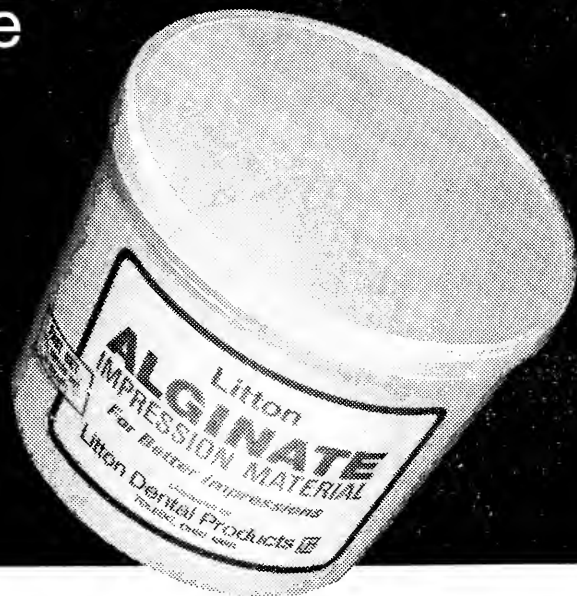
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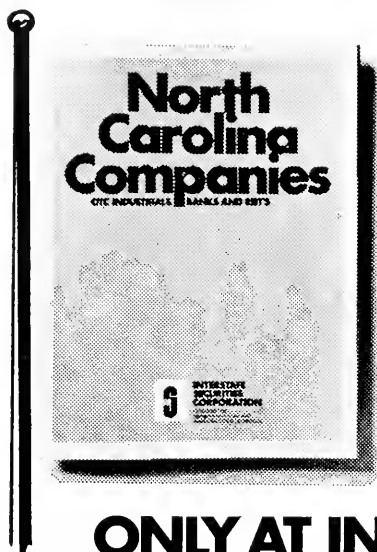


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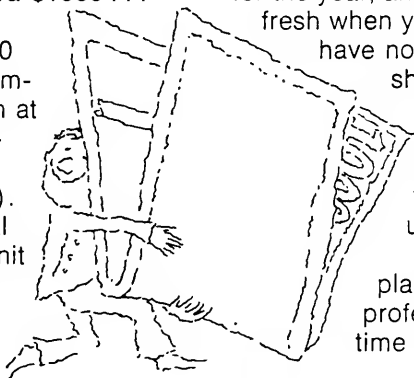
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